vitalcare® INFUSION SERVICES

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DERMATOLOGY REFERRAL FORM

Please Attach Copy of Insurance Cards (Front & Back)

Last Name:	First Name:	DOB:	Practice:
Address:			Address:
City:	State:	Zip: Sex: ○M ○F	City: State: Zip:
Phone:	SSN#		Prescriber Name:
INSURANCE INFORMATION			Prescriber NPI:
Insurance Plan:	Insurance Plan:		Nurse/Key Contact:
Policy #	Policy #		Phone:
Plan I.D. #	Plan I.D. #		Fax: Email:

CLINICAL INFORMATION – STATEMENT OF MEDICAL NECESSITY

Please Attach Clinical/Progress Notes, Labs, Test, Supporting Primary Diagnosis

Diagnosis: ☐ L40.8 Moderate to Severe Plaque Psoriasis ☐ L40.50 Psoriatic Arthritis ☐ L73.2 Hidradenitis Suppurativa
☐ L20.9 Atopic Dermatitis ☐ Other: _____

Severity of Condition: ☐ Mild (up to 3% BSA) ☐ Moderate (3-10% BSA) ☐ Severe (>10% BSA) BSA%: _____

Location: ☐ Hands ☐ Feet ☐ Scalp ☐ Groin ☐ Nails ☐ Other: _____

Prior Failed Meds: ☐ Methotrexate Length of Treatment _____ Reason for Discontinuing _____
☐ PUVA/UVB Length of Treatment _____ Reason for Discontinuing _____
☐ Topicals Length of Treatment _____ List Specific Meds _____
☐ Other Length of Treatment _____ List Specific Meds _____

TB/PPD Test given? ☐ Yes ☐ No Results _____ Date _____ Allergies _____

PRESCRIPTION INFORMATION

Medication	Dose/Strength	Directions	Quantity	Refills
Adalimumab	☐ Psoriasis Starter Kit ☐ 40mg Pen ☐ 40mg PFS ☐ Psoriasis Starter Kit CF ☐ 40mg CF Pen ☐ 40mg CF PFS	☐ Initial Dose: Inject 80mg SC on day 1, 40mg on day 8, then maintenance dose every other week thereafter	1 starter kit	
		☐ Maintenance Dose: Inject 40mg SC every other week	28 day supply	
Cimzia®	☐ 200mg Vial Kit	☐ Initial Dose: Inject 400mg SC at weeks 0, 2, and 4 ☐ Maintenance: Inject 400mg SC every 2 weeks		
Cosentyx®	☐ 150mg Sensoready Pen ☐ 150mg Prefilled Syringe	Initial Dose: Inject ☐ 300mg or ☐ 150mg SC week 0, 1, 2, 3, 4	28 day supply	0
		Maintenance Dose: Inject ☐ 300mg or ☐ 150mg SC every 4 weeks	28 day supply	
Dupixent®	☐ 200mg/1.14mL Prefilled Pen ☐ 200mg/1.14mL Prefilled Syringe ☐ 300mg/2mL Prefilled Pen ☐ 300mg/2mL Prefilled Syringe	**Adults and pediatric ≥ 60kg:** ☐ 600 mg (two 300 mg injections) followed by 300 mg every 2 weeks **Pediatric Patients <60kg** ☐ 5 to less than 15kg: Initial Dose 200mg (one 200mg injection); Subsequent Doses 200mg every 4wks ☐ 15 to less than 30kg <6yr: Initial Dose 300mg (one 300mg injection); Subsequent Doses 300mg every 4wks ☐ 15 to less than 30kg ≥ 6yr: Initial Dose 600mg (two 300mg injections); Subsequent Doses 300mg every 4wks ☐ 30 to less than 60kg: Initial Dose 400mg (two 200mg injections); Subsequent Doses 300mg every 4wks	28 day supply	
Enbrel®	☐ 50mg Sureclick Autoinjector ☐ 50mg PFS ☐ 50mg mini ☐ 25mg PFS ☐ 25mg Vials	☐ Inject SC twice a week 72-96 hours apart ☐ Inject SC once a week ☐ Inject _____ mg (0.8mg/kg X _____kg SC every week (≤63 kg) Other:	28 day supply	
Humira® HS	☐ HS Starter Kit ☐ 40mg Pen ☐ 40mg PFS ☐ HS Starter Kit CF ☐ 40mg CF Pen ☐ 40mg CF PFS ☐ 80mg CF Pen	☐ Initial Dose: Inject 160mg SC on day 1, 80mg on day 15, then 40mg every week beginning on day 29	1 starter kit	
		☐ Maintenance Dose: (At week 4) Inject 40mg SC weekly ☐ Inject 80mg every other week	28 day supply	
Ilumya	☐ 100mg PFS	☐ Inject 100mg at weeks 0, 4, and every 12 weeks thereafter		
Infliximab	☐ 100mg Vial	☐ Infuse 5mg/kg at 0, 2 and 6 weeks, then every 8 weeks		
Simponi®	☐ 50mg SmartJect ☐ 50mg PFS	☐ Inject 50mg SC once a month as directed	28 day supply	
Skyrizi®	☐ 75mg 2 PFS Kit ☐ 150mg Pen ☐ 150mg PFS	☐ Initial Dose: Inject 150mg SC on week 0 and 4	1	0
		☐ Maintenance: Inject 150mg SC every 12 weeks	1	
Stelara®	☐ 45mg Vial	☐ (<220 lbs) Inject 45mg on day 0 then week 4, followed by 45mg dose every 12 weeks ☐ (>220 lbs) Inject 90mg on day 0 then week 4, followed by 90mg dose every 12 weeks	28 day supply	
Taltz®	☐ 80mg Autoinjector Pen ☐ 80mg Prefilled Syringe	☐ Initial Dose: Inject 160mg SC at week 0 then 80mg at weeks 2, 4, 6 , 8, 10 and 12	28 day supply	
		☐ Maintenance Dose: Inject 80mg SC every 4 weeks	28 day supply	
Tremfya™	☐ 100mg Prefilled Pen ☐ 100mg Prefilled Syringe	☐ Initial Dose: Inject 100mg SC at week 0 and 4	2	0
		☐ Maintenance: Inject 100mg SC every 8 weeks	1	
Other				

Ship Medications To: ☐ Physician's Clinic ☐ Patient's Home **Injection Training Needed:** ☐ Yes ☐ No

I authorize Vital Care Infusion Services LLC and its representatives to initiate any insurance prior authorization process that is required for this prescription and for any future refills of the same prescription for the patient listed above which I order. I understand that I can revoke this designation at any time by providing written notice to Vital Care.

Physician Signature: _____

Date: _____

PRESCRIBER MUST MANUALLY SIGN - STAMP SIGNATURE, SIGNATURE BY OTHER PERSONNEL AND COMPUTER-GENERATED SIGNATURES WILL NOT BE ACCEPTED