Faxed prescription will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy. Prescribers are reminded patients may choose any pharmacy of their choice.

Dermatology Prescription Referral Form

1403 Highway 6 Suite 700A, Sugar Land, TX 77478 **Phone: 832.944.6112** **Fax: 832.944.6116**

Choice Infusion Center "Infuse to better health"

Patient Information

Patient Name: _____ **Birthdate:** _____ **Sex:** _____ Male _____ Female **Height:** _____ **Weight:** _____ lbs. _____ kg.

Soc. Sec. #: _____ **Preferred Phone:** _____ **Known Allergies:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Alternate Caregiver Name: _____ **Preferred Phone:** _____

Insurance Information: Please fax FRONT and BACK copy of ALL Insurance cards (prescription and medical)

Prescriber Information

Name: _____ **DEA#:** _____ **NPI#:** _____ **Tax ID#:** _____

Address: _____ **Phone:** (_____) _____ - _____ **Fax:** (_____) _____ - _____

City: _____ **State:** _____ **Zip:** _____ **Key Contact:** _____ **Phone:** (_____) _____ - _____

Diagnosis/Clinical Information

Please FAX recent clinical notes, Labs, Tests, with the prescription to expidite the Prior Authorization

Diagnosis: _____

Date of diagnosis (or years with disease): _____

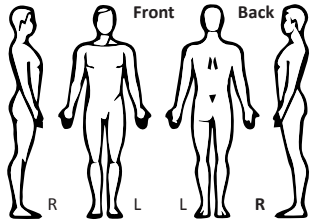
Has patient been treated previously for this condition? __ Yes __ No

If yes, medication/therapy failed (length of therapy): _____

Has patient receive PPD (tuberculosis) Skin Test? __ Yes __ No

Has Hepatitis B been ruled or treatment been initiated? __ Yes __ No

Does patient have a latex allergy? __ Yes __ No



_____% BSA affected by Psoriasis

Prescription Information

Medication	Dose/Strength	Sig	Qty.	Refills
__ **Enbrel®**	__ 50mg/ml Prefilled Syringe __ 50mg/ml Sureclick® Autoinjector __ 25mg/0.5ml Prefilled Syringe	__ **Induction Dose:** Inject 50mg SC TWICE a week (72-96 hours apart for three months) __ **Maintenance Therapy:** Inject 50mg SC ONCE a week **Other:** _____		
__ **Humira®** Injection training from My Humira (patient must sign below)	__ 20mg/0.4 Prefilled Syringe (2 doses) __ 40mg/0.8ml Pen (2 doses) __ 40mg/0.8 Prefilled Syringe (2 doses) __ 40mg kit 4x0.8ml __ 40mg starter kit 6x0.8ml	__ **Initial Dose:** Inject 80mg SC on Day 1 __ **Maintenance Therapy:** Inject 40mg SC every OTHER week (starting 1 week after initial dose) **Other:**_____	Initial Dose: 1 Other:	
__ **Stelara®**	__ 45mg/0.5ml Prefilled Syringe __ 90mg /1ml Prefilled Syringe	__ **Starter Dose:** Inject 45mg SC (patient<100kg) at Day 1 Inject 90mg SC (patient<100kg) at Day 1 __ **Maintenance:** Inject 45mg SC (patient<100kg) 29days after starter dose and then every 12 weeks Inject 90mg SC (patient<100kg) 29days after starter dose and then every 12 weeks **Other:** _____	Initial Dose: 1 Other:	
__ **Otezla®**	***Please use Otezla-specific referral form***			
__ **Oxsoralen-Ultra®**	__ 10mg			
__ **Zolinza®**	__ 40mg	400mg ONCE daily **Other:**		

Date Medication Needed: ____/____/_____ **Ship To:** ____ Patient's Home _____ Prescriber's Office _____ Pick-up (store location): _____ Injection Training by Pharmacy

Patient Support Programs: Please sign and date below to enroll in the pharmaceutical company assisted patient support program

Patient Signature: **Date:**

Prescriber Signature: Prescriber, please sign and date below

Dispense as written **Date:** **Substitution Permissable** **Date**

# of Prescriptions: _____