CureStat Rx
Home Infusion and Specialty Pharmacy

DERMATOLOGY(H-O) REFERRAL FORM

Phone: (888)963-6544 Fax: (858)281-0045

PATIENT INFORMATION ☐ Deliver Here

Patient Name: _____
DOB: _____ Gender: ☐ Male ☐ Female
Address: _____
City_____ State_____ Zip: _____
Primary Phone: _____ SSN: _____
Caregiver Name: _____
Alternate Phone: _____
Please fax a copy of front and back of insurance card(s).

PRESCRIBER INFORMATION ☐ Deliver Here

Prescriber Name: _____
State License #: _____ DEA #: _____
NPI #: _____
Address: _____
City_____ State_____ Zip: _____
Phone: _____ Fax: _____
Contact Person: _____ Phone: _____

Clinical Information

Diagnosis: ☐L20. ____ (Atopic Dermatitis) ☐ L40.0 (Psoriasis vulgaris/Plaque Psoriasis/Nummular Psoriasis) ☐L40.8 (Other psoriasis)
☐L40.9 (Psoriasis, unspecified) ☐L40.5____ (Psoriatic arthritis) ☐L73.2 (Hidradenitis Suppurativa)
☐ Other (ICD 10 code and description): _____ Wt: _____ ☐ Kg ☐ lbs Ht: _____ ☐ cm ☐ in
Diagnosis Date: _____ TB/PPD test: ☐ Positive ☐ Negative HBV: ☐Yes ☐No If yes, currently treated: ☐Yes ☐No
Prior Therapy: ☐ Yes ☐ No _____
Reason for Discontinuation of therapy: _____
Start Date: __ __/__ __/__ __ __ __ End Date: __ __/__ __/__ __ __ __
Allergies: ☐ NKDA ☑ Other: _____
Comorbidities: _____
Concomitant Medications: _____

Drug	Dose/Strength	Directions	Qty	Refills
☐ **HUMIRA** (Adalimumab)	☐ 40mg/0.8mL Pen ☐ 40mg/0.4mL Pen ☐ 40mg/0.8mL Prefilled Syringe ☐ 40mg/0.4mL Prefilled Syringe ☐ 80 mg/0.8 mL Pen ☐ 80 mg/0.8 mL Prefilled Syringe	**Psoriatic arthritis and plaque psoriasis** ☐ Inject 40mg SC every other week **Plaque Psoriasis** ☐ Loading Dose: Inject 80mg SC on Day 1 **Hidradenitis Suppurativa (≥12yrs & weigh ≥60kg)** ☐ Loading dose: Inject 160mg on day 1, 80mg on day 15 and 40mg on day 29 ☐ Maintenance dose: Inject 40mg SC every week **Hidradenitis Suppurativa (≥12yrs & weigh 30kg to <60kg)** ☐ Loading dose: Inject 80mg SC on day 1 followed by 40mg on day 8 ☐ Maintenance dose: Inject 40mg SC every other week		
☐ **ILUMYA** (tildrakizumab-asmn)	☐ 100 mg/mL prefilled syringe	☐ Loading Dose: Inject 100mg SC at week 0 and 4 ☐ Maintenance Dose: Inject 100mg SC every 12 weeks		
☐ **ORENCIA** (abatacept)	☐ 250mg vial ☐ 125mg/mL prefilled syringe ☐ 125mg/mL ClickJect autoinjector	**Patients weighing <60kg** ☐ Infuse 500mg at week 0, 2 and 4 weeks over 30 mins ☐ Infuse 500mg every 4 weeks over 30 mins **Patients weighing 60-100kg** ☐ Infuse 750mg at week 0, 2 and 4 weeks over 30 mins ☐ Infuse 750mg every 4 weeks over 30 mins **Patients weighing >100kg** ☐ Infuse 1000mg at week 0, 2 and 4 weeks over 30 mins ☐ Infuse 1000mg every 4 weeks over 30 mins ☐ Inject 125mg SC once weekly		
☐ **OTEZLA** (apremilast)	☐ 28-day starter pack ☐ 30mg tablet	☑ Take as directed by starter pack ☑ Take 30mg by mouth twice daily		

Injection training provided by: ☐ Prescriber's office ☐ Pharmacy ☐ Other: _____

☐ Product substitution permitted ☐ Dispense as written

Prescriber's Signature: _____ Date: _____