CureStat Rx
Home Infusion and Specialty Pharmacy

DERMATOLOGY(S-Z) 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
☐ **SILIQ** (brodalumab)	☐ 210 mg/1.5 mL prefilled Syringe	☐ Loading Dose: Inject 210mg SC at Weeks 0, 1, and 2 ☐ Maintenance Dose: Inject 210mg SC every 2 weeks		
☐ **SIMPONI** (golimumab)	☐ 50 mg/0.5 mL prefilled syringe ☐ 50 mg/0.5 mL autoinjector	☐ Inject 50mg SC once a month		
☐ **SIMPONI ARIA** (golimumab)	☐ 50 mg/4 mL vial	☐ Loading Dose: Infuse _____mg (2mg/kg) IV over 30 mins at weeks 0 and 4 ☐ Maintenance Dose: Infuse _____mg (2mg/kg) IV over 30 mins every 8 weeks		
☐ **STELARA** (ustekinumab)	☐ 45 mg/0.5 mL prefilled syringe ☐ 90 mg/mL prefilled syringe ☐ 45 mg/0.5 mL vial	**Adolescents (≥12yrs) and weighing <60 kg** ☐ Loading Dose: Inject ____ mg (0.75mg/kg) SC at week 0 and 4 ☐ Maintenance Dose: Inject ____ mg (0.75mg/kg) SC every 12 weeks **Adults weighing ≤ 100kg & adolescents (≥12yrs) weighing 60kg to 100kg** ☐ Loading Dose: Inject 45mg SC at week 0 and 4 ☐ Maintenance Dose: Inject 45mg SC every 12 weeks **Adults and adolescents weighing >100kg** ☐ Loading Dose: Inject 90mg SC at week 0 and 4 ☐ Maintenance Dose: Inject 90mg SC every 12 weeks		
☐ **TALTZ** (ixekizumab)	☐ 80 mg/mL prefilled syringe ☐ 80 mg/mL autoinjector	**Plaque Psoriasis** ☐ Loading dose: Inject 160mg SC at week 0 followed by 80mg at week 2, 4, 6, 8, 10, and 12 **Psoriatic Arthritis** ☐ Loading dose: Inject 160mg SC at week 0 ☐ Maintenance dose: Inject 80mg SC every 4 weeks		
☐ **TREMFYA** (guselkumab)	☐ 100 mg/mL prefilled syringe ☐ 100 mg/mL One Press injector	☐ Inject 100mg SC at week 0 and 4 ☐ Inject 100mg SC every 8 weeks		
☐ **XELJANZ** (tofacitinib)	☐ 5mg tablet ☐ 11mg XR tablet	☐ Take 5mg by mouth twice daily ☐ Take 11mg by mouth once daily		

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

☐ Product substitution permitted ☐ Dispense as written

Prescriber's Signature: _____ Date: _____