echocare SPECIALTY PHARMACY

"Your partner in patient care"

260 Broadway
Brooklyn, NY 11211
Phone: 718-782-0101
Fax: 718-782-2626
www.EchoDrugs.net

DERMATOLOGY REFERRAL FORM

Fax prescription to: 718-782-2626

Faxed prescriptions can only be accepted from prescribing practitioners

Date Needed By _____ Ship to: ☐ Patient ☐ Office ☐ Other: _____

PATIENT INFORMATION

Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ SS# _____ DOB _____

☐ Male ☐ Female Height _____ Weight _____ Age _____

Allergies _____ ☐ NKDA

INSURANCE INFORMATION

Please attach front and back of all insurance and prescription drug cards

PRESCRIBER INFORMATION

Name _____

NPI _____ State License# _____

Group/Hospital _____

Address _____

City, State, Zip _____

Main Phone _____ Fax _____

Contact Person _____ Phone _____

CLINICAL EVALUATION

DIAGNOSIS

☐ L40.9 Psoriasis
☐ L40.52 Psoriatic Arthritis
☐ L73.2 Hidradenitis Suppurativa
☐ L20.9 Atopic Dermatitis
☐ Other _____

Diagnosis Date _____

Years with disease _____

Psoriasis Type: ☐ Moderate ☐ Severe

Psoriasis Severity: ☐ Plaque ☐ Other _____

LABS

Has TB test been performed? ☐ Yes *(If yes, please attach results)* ☐ No

Lab Date _____ TB Results _____

Comments:

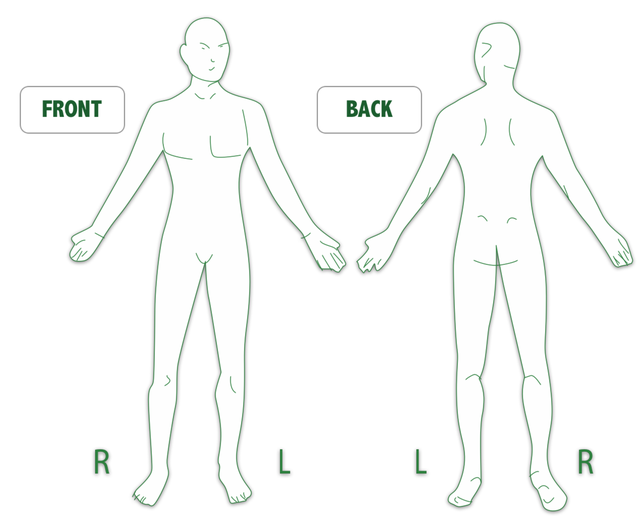
PREVIOUS TREATMENTS

Medication	Reason for discontinuation
☐ Biologics	
☐ Methotrexate	
☐ Oral Meds (other)	
☐ PUVA	
☐ UVB	
☐ Topicals	
☐ Other	

MEDICAL ASSESSMENT

Has patient been diagnosed with heart failure? ☐ Yes ☐ No
Has patient been diagnosed with lymphoma? ☐ Yes ☐ No
Does patient have serious/active infection? ☐ Yes ☐ No
Is patient at risk for Hepatitis B infection? ☐ Yes ☐ No
If yes, has Hepatitis B been ruled out or treatment initiated? ☐ Yes ☐ No
Does patient have latex allergy? ☐ Yes ☐ No
Is patient platelet count greater than 52,000 cells/uL? ☐ Yes ☐ No

INDICATE AFFECTED AREAS



Weight _____ Height _____ BSA% affected by Psoriasis _____

Comments _____

_____

PRESCRIPTION INFORMATION

MEDICATION	DOSAGE & DIRECTIONS	QUANTITY/DURATION	REFILLS
☐ **CIMZIA (certolizumab pegol)** ☐ 400mg x 3 Starter Kit ☐ 400mg pen (200mg x 2)	☐ Psoriasis/Psoriatic Arthritis loading dose: 400mg week 0, 2, 4 ☐ Psoriasis/Psoriatic Arthritis maintenance dose: 400mg every 4 weeks		
☐ **COSENTYX (secukinumab)** ☐ 150mg syringe ☐ 150mg pen	☐ Psoriatic arthritis induction (optional): 150mg subcutaneously at weeks 0, 1, 2, 3, and 4 ☐ Psoriatic arthritis maintenance: 150mg subcutaneously every 4 weeks ☐ Plaque Psoriasis induction: 300mg subcutaneously at weeks 0, 1, 2, 3, and 4 ☐ Plaque Psoriasis maintenance: 300mg subcutaneously every 4 weeks		
☐ **DUPIXENT (dupilumab)** ☐ 300mg/2ml prefilled syringe ☐ 300mg/2ml pen	☐ Atopic Dermatitis induction: Inject 600mg subcutaneously in 2 different injection sites ☐ Atopic Dermatitis maintenance: Inject 300mg subcutaneously every other week		
☐ **ENBREL (etanercept)** ☐ 50mg SureClick ☐ 300mg/2ml prefilled syringe	☐ Psoriasis loading dose: 50mg subcutaneously TWICE weekly for 3 months ☐ Psoriasis/Psoriatic Arthritis maintenance dose: 50mg subcutaneously EACH week		
☐ **HUMIRA (adalimumab)** ☐ 40mg/0.4ml pen ☐ 40mg/0.4ml syringe ☐ Psoriasis Starter Pack ☐ HS Starter Pack	☐ Psoriasis starter: 80mg day 1, 40mg day 8, 40mg every 2 weeks ☐ Psoriasis maintenance: 40mg subcutaneously every 2 weeks ☐ HS starter: 160mg day 1, 80mg day 15, 40mg EACH week starting day 29 ☐ HS maintenance: 40mg subcutaneously EACH week		
☐ **ILUMYA (tildrakizumab-asmn)** ☐ 100mg syringe	☐ Psoriasis: 100mg at weeks 0, 4, then ONCE every 12 weeks		
☐ **OTEZLA (apremilast)** ☐ Otezla Starter Pack ☐ 30mg tab	☐ Psoriasis/Psoriatic Arthritis starter dose: titration directions on pack ☐ Psoriasis/Psoriatic Arthritis maintenance dose: 30mg TWICE a day		
☐ **SKYRIZI (risankizumab-rzaa)** ☐ 150mg (2x75mg syringe)	☐ Psoriasis: 150mg at weeks 0, 4, then ONCE every 12 weeks		
☐ **STELARA (ustekinumab)** ☐ 45mg ☐ 90mg	☐ Plaque Psoriasis/Psoriatic Arthritis (<100kg): 45mg subcutaneously at weeks 0, 4, then every 12 weeks ☐ Plaque Psoriasis/Psoriatic Arthritis (>100kg): 90mg subcutaneously at weeks 0, 4, then every 12 weeks		
☐ **TREMFYA (guselkumab)** ☐ 100mg pen ☐ 100mg syringe	☐ Plaque Psoriasis/Psoriatic Arthritis: 100mg subcutaneously at weeks 0, 4, then every 8 weeks		
☐ **XELJANZ (tofacitinib citrate)** ☐ 11mg XR tab ☐ 5mg tab	☐ Psoriatic Arthritis: 5mg TWICE daily ☐ Psoriatic Arthritis: 11mg ONCE daily		
☐ **OTHER:**	☐ Directions:		

By signing this form and utilizing our services, you are authorizing Echo Care Specialty Pharmacy and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature _____ ☐ DAW Date _____

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