



University Specialty Pharmacy
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Dermatology Referral Form

Patient Name: (First) _____		(Last) _____	
Address: _____		City: _____	State: _____ Zip: _____
Home Ph: _____	Cell Ph: _____	Work Ph: _____	SS#: _____
Date of Birth: _____	Patient's Height: _____	Patient's Weight: _____	Male <input type="checkbox"/> Female <input type="checkbox"/>
Parent/Guardian if child: _____		Address: _____	
Primary Insurance: _____		Phone: () _____	PLEASE ATTACH COPY OF CARD!
Cardholder Name: _____	ID# _____	Group# _____	Employer: _____
Patient Drug Allergies: _____			

CLINICAL INFORMATION	<input type="checkbox"/> Psoriasis	<input type="checkbox"/> Psoriatic Arthritis	<input type="checkbox"/> Other _____	Date of Diagnosis _____
Location of Psoriasis: <input type="checkbox"/> Hands <input type="checkbox"/> Feet <input type="checkbox"/> Scalp <input type="checkbox"/> Groin <input type="checkbox"/> Nails <input type="checkbox"/> Other _____				
Severity of Psoriasis: <input type="checkbox"/> Mild (up to 3% BSA) <input type="checkbox"/> Moderate (3 -10% BSA) <input type="checkbox"/> Severe (greater than 10% BSA); BSA _____ %				
Has patient been previously treated for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No Medications failed: _____				
Is patient currently on other therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No What: _____				

PRESCRIPTION	
<input type="checkbox"/> Humira® <input type="checkbox"/> Embrel® <input type="checkbox"/> Amevive® <input type="checkbox"/> Simponi® <input type="checkbox"/> Other _____	
SIG: Inject Dose: _____mg <input type="checkbox"/> SQ <input type="checkbox"/> IM Frequency: _____	
Dispense Quantity: _____ Refills: _____	
Other Instructions: _____	
Deliver Product to: <input type="checkbox"/> Office <input type="checkbox"/> Patient's Home <input type="checkbox"/> Other: _____	
_____ Physician's Signature	_____ Date
Physician Name: _____ Address: _____	
City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____	
DEA #: _____ License #: _____ NPI#: _____ State: _____	
Office Contact: _____ Email: _____	

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