QueensExpressPharmacy
Your Specialty and IV-Compounding Pharmacy

34-54 Junction Blvd
Jackson Heights, NY 11372
Phone: (718) 565-1009
Fax: (718) 565-1004
www.QEPHEALTH.com

DERMATOLOGY REFERRAL FORM

Fax prescription to: 718-565-1004

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 ☐ Moderate to Severe ☐ Severe

PSORIASIS SEVERITY

☐ Plaque ☐ Other _____

PREVIOUS TREATMENTS

Medication	Reason for discontinuation
☐ Biologics	
☐ Methotrexate	
☐ Oral Meds	
☐ PUVA	
☐ UVB	
☐ Topicals	
☐ Other:	
☐ Other:	

LABS

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

Lab Date _____ TB Results _____

Comments _____

MEDICAL ASSESMENT

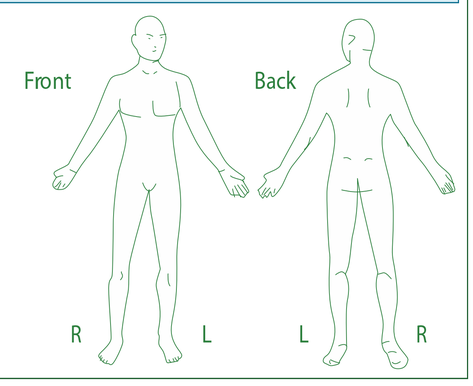
Has patient been diagnosed with heart failure? ☐ Yes ☐ No
Has patient been diagnosed with lymphoma? ☐ Yes ☐ No
Does patient have serious/active infection? ☐ Yes ☐ No
Is patient at risk for Hepatitis B infection? ☐ Yes ☐ No
If yes, has Hepatitis B been ruled out or treatment initiated? ☐ Yes ☐ No
Does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

Weight _____ Height _____

BSA% affected by Psoriasis _____

Comments _____

_____



PRESCRIPTION INFORMATION

MEDICATION	DOSAGE & DIRECTIONS	QUANTITY/DURATION	REFILLS
☐ **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 (optional): 300mg subcutaneously at weeks 0, 1, 2, 3, and 4 ☐ Plaque Psoriasis maintenance: 300mg subcutaneously every 4 weeks ☐ Other:	☐ Enter quantity _____	
☐ **DUPIXENT (dupilumab)** ☐ 300mg/2ml prefilled syringe	☐ Induction: Inject 600mg subcutaneously in 2 different injection sites ☐ Maintenance: Inject 300mg subcutaneously every other week ☐ Other _____	☐ Enter quantity _____	
☐ **HUMIRA (adalimumab)** ☐ 40mg/0.8ml pen ☐ 40mg/0.8ml prefilled syringe ☐ Chron's/UC Starter Kit	☐ Induction: Inject 160mg (4 pens) subcutaneously on day 1, then 80mg (2 pens) on day 15 ☐ Maintenance: Inject 40mg (1 injection) subcutaneously every other week ☐ Other _____	☐ Enter quantity _____	
☐ **REMICADE (infliximab)** ☐ 100mg vial	☐ Induction: IV at 5mg/kg (Dose = _____ mg) at weeks 0, 2, and 6 ☐ Maintenance: IV at 5mg/kg (Dose = _____ mg) every 8 weeks ☐ Other _____	☐ Enter quantity _____	
☐ **SIMPONI (golimumab)** ☐ 100mg SmartJect ☐ 100mg prefilled syringe	☐ Induction: Inject 200mg subcutaneously at week 0, then 100mg at week 2 ☐ Maintenance: Inject 100mg subcutaneously every 4 weeks	☐ Enter quantity _____	
☐ **VIBERZI (eluxadoline)** ☐ 100mg tablets ☐ 75mg tablets	☐ IBS with diarrhea: 100mg twice a day ☐ Patients WITHOUT gallbladder: 75mg twice a day	☐ Enter quantity _____	
☐ **XIFAXAN (rifaximin)** ☐ 550mg tablets	☐ Hepatic Encephelopathy: 550mg twice a day ☐ IBS with diarrhea: Inject 550mg 3 times a day	☐ Enter quantity _____	
☐ **OTHER _____**	☐ Directions _____	☐ Enter quantity _____	

By signing this form and utilizing our services, you are authorizing Queens Express 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 _____