SimfaRose
Pharmaceutical Specialties
Your Symphony Of Healthcare • Transition Care Specialist

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Dermatology Order Form

Today's Date: _____ Date Medication Needed: _____

Patient Information

Last Name: _____ First Name: _____

Date of Birth: _____ Social Security: _____ ❑Male ❑Female

Address: _____ City: _____ State:_____ Zip:_____

Home Phone: _____ Cell Phone: _____

Diagnosis/ICD-10 Code:_____ Height / Weight / Allergies: _____

Insurance: _____ Policy #: _____ ***Please include copy of insurance card***

Clinical:

TB/PDD Test Given? ❑ Yes ❑ No Date of Test? ____/_____/_____ Does the patient have an active infection? ❑ Yes ❑ No
Affected Areas: ❑Palms ❑Soles ❑ Head ❑Neck ❑Genitalia ❑Other: _____ BSA Affected (%): _____
Prior Therapy:_____ Date Started: ____/_____/____ Date Ended: ____/_____/____
Prior Therapy:_____ Date Started: ____/_____/____ Date Ended: ____/_____/_____
Prior Therapy:_____ Date Started: ____/_____/____ Date Ended: ____/_____/____

℞ Prescription:

❑ **Enstilar®** 0.005%/0.064% Foam
Sig: _____ Qty: ❑60gm ❑120gm Refills:_____

❑ **Picato®** ❑ 0.015% ❑0.05% Gel
Sig: _____ Qty: 3gm Refills:_____

❑ **Taclonex®** 0.005%/0.064% Topical/Suspension
Sig: _____ Qty: ❑60gm ❑120gm Refills:_____

❑ **Humira®** 40mg/0.8ml
□ Starting Therapy: □ Inject 80 mg Sub-Q Day 1, then 40 mg on Day 8, then 40 mg every 2 weeks thereafter No Refills
□ Maintenance: □ Followed by 40 mg every other week starting one week after initial dose Refills: _____

❑ **Enbrel®** □ 50mg/ml SureClick Autoinjector □ 50mg/ml Prefilled Syringe □ 25mg/ml Vial □ 25mg/0.5ml Prefilled Syringe
□ For Psoriasis: □ Initial Dose: Inject 50mg SQ twice weekly for 3 months No Refills
□ Maintenance: Inject 50mg SQ weekly Refills: _____
□ For Psoriatic Arthritis: Initial Dose: Inject 50mg SQ once weekly Refills: _____

❑ **Stelara®** □ 45mg/0.5ml Prefilled Syringe □ 90mg/ml Prefilled Syringe
□ For patients weighing <100kg (220 lbs): Inject 45mg SQ initially and 4 weeks later, followed by 45mg every 12 weeks Refills: _____
□ For patients weighing >100kg (220 lbs): Inject 90mg SQ initially and 4 weeks later, followed by 90mg every 12 weeks Refills: _____

❑ **Other:** _____
Sig: _____
_____ Qty: ____ Refills:_____

MD Signature:_____ Date:_____

MD Name (Printed):_____ NPI:_____ DEA:_____

Phone:_____ Fax:_____ Contact:_____

Address:_____ City:_____ State:_____ Zip:_____