MedicoRx Specialty
& HOME INFUSION PHARMACY

DERMATOLOGY Referral Form

Phone: 818-390-9696 Toll-free: 855-265-7850 • Fax: 818-390-9697 Toll-free fax: 855-450-6717 • info@MedicoRX.com

Patient information		Prescriber information	
Name:	**DOB:**	**Prescriber's Name:**	
Address: **City, State, Zip**		**NPI#**	
		DEA#	**License#**
Phone #	**Alt#**	**Address** **City, State, Zip**	
SSN:			
Height:	**Wt:**	**Phone #**	**Fax #**
Allergies:			
Emergency Contact/ Phone #		**Contact Person:**	

Clinical Consideration	
Diagnosis (ICD 10)	□ B08.8 Other specified viral infections characterized by skin and mucous membrane lesions □ L08.89 Other specified local infections of the skin and subcutaneous tissue □ L20.8 Other atopic dermatitis: ***Eczema*** □ L20.9 Atopic dermatitis, unspecified
Other (please specify) _____	

Medication	Dose/Strength	Directions for Use	Quantity	Refills
□ **Sivextro®** (Tedizolid Phosphate)	□ 200 mg IV □ 200 mg Tablet	□ Once Daily for 6 Days □ Once Daily for 6 Days		
□ **Zyvox®** (Linezolid)	□ 600 mg IV □ 600 mg Tablet	□ Twice Daily □ Twice Daily		
□ **Picato®** (Ingenol Mebutate Gel)	□ 0.015% (face/scalp tx) □ 0.05% (body tx)	□ Apply 1 tube per day for 3 consecutive days □ Apply 1 tube per day for 2 consecutive days		
□ **Eucrisa®** (Crisaborole 2% Ointment)	□ 2% (20mg / gram)	□ Apply a thin layer of EUCRISA twice daily to affected areas.		
□ **Dupixent®** (Dupilumab 300mg/2ml)	□ 300 mg PFS	□ ***Loading Dose*** Inject an initial dose of 600mg (2 PFS) in different injection sites. □ ***Maintenance Dose*** Inject 300mg (1 PFS) Every Other Week		
□ **Tremfya®** (Guselkumab)	□ 100 mg PFS	□ **Starter Dose**: Inject 100 mg SQ at week 0, 4 and every 8 weeks thereafter □ **Maintenance Dose**: Inject 100 mg SQ every 8 weeks	□ One Carton □ Two Cartons	
□ **Efudex®** (5% fluorouracil)	□ 2% Solution □ 5% Solution □ 5% Cream	□ Apply cream or solution twice daily in an amount sufficient to cover the lesions.	□ 10ml □ 25ml □ 40gm	
□ **Carac® Cream, 0.5%** (5% fluorouracil)		□ Apply once a day to the skin where actinic keratosis lesions appear.	□ 30gm	

By signing this form I authorize MedicoRX and its representatives to act as my agent in order to initiate and execute the insurance prior authorization process and, in doing so release clinical information via phone to the appropriate third party payer.

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Prescriber's signature (no stamps) if brand required check this ☐ DAW___ **Date**