

### 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
<b>Diagnosis (ICD 10)</b> <input type="checkbox"/> B08.8 Other specified viral infections characterized by skin and mucous membrane lesions <input type="checkbox"/> L08.89 Other specified local infections of the skin and subcutaneous tissue <input type="checkbox"/> L20.8 Other atopic dermatitis: <b>Eczema</b> <input type="checkbox"/> L20.9 Atopic dermatitis, unspecified Other (please specify) _____

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

Prescriber's signature (no stamps) if brand required check this  DAW \_\_\_\_\_

Date \_\_\_\_\_