COOKEVILLE REGIONAL MEDICAL CENTER
It's the Way WeCARE

Dermatology Referral Form

FOR INFORMATION
Specialty Services: (931) 783-5551
Fax referral #: (931) 783-5533
Outpatient Pharmacy
931-783-2552 phone
931-783-2553 fax

Referral Info

PATIENT INFORMATION

Patients Name:		SSN#:		DOB:	
Address:		City:	State:	Zip:	
Home Phone:	Cell Phone:	Height:	Weight:	Gender: Male	Female
Email Address:		Diagnosis Code:			

INSURANCE INFORMATION (or attach copy of your cards)

Primary Insurance Co:	Phone:	Policy#:	Group#:
Secondary Insurance Co:	Phone:	Policy#:	Group#:

PRESCRIPTION INFORMATION (For IV medications attach a copy of your prescription.)

To prevent generic substitution, Prescriber to handwrite "Brand Medically Necessary" and sign:

MEDICATIONS

❑ CIMZIA®	❑ INDUCTION	❑ MAINTENANCE	
❑ COSENTYX®	❑ INDUCTION	❑ BRIDGE*	❑ MAINTENANCE
❑ DUPIXENT	❑ INDUCTION	❑ MAINTENANCE	
❑ ENBREL®	❑ INDUCTION	❑ MAINTENANCE	
❑ HUMIRA® CITRATE-FREE	❑ STARTER PACK	❑ MAINTENANCE	
❑ HUMIRA®	❑ STARTER PACK	❑ MAINTENANCE	
❑ OTEZLA®	❑ TITRATION PACK	❑ BRIDGE	❑ MAINTENANCE
❑ STELARA®	❑ INDUCTION	❑ MAINTENANCE	
❑ SIMPONI®	❑ INDUCTION	❑ MAINTENANCE	
❑ TALTZ®	❑ INDUCTION	❑ MAINTENANCE	
❑ SILIQ™	❑ INDUCTION	❑ MAINTENANCE	
❑ TREMFYA™	❑ INDUCTION	❑ MAINTENANCE	
❑ ILUMYA™	❑ INDUCTION	❑ MAINTENANCE	

*Covered Until You're Covered Program

PRIMARY DIAGNOSIS

❑ Moderate to Severe Plaque Psoriasis ❑ Psoriatic Arthritis
❑ Hidradentis Suppurativa ❑ Atopic Dermatitis
❑ Other: _____ Date of Diagnosis: _____

Please use this section for additional directions or other medications not listed.

❑ OTHER

STRENGTH:

SIG/DIRECTIONS

INDUCTION STARTER

STRENGTH:

SIG/DIRECTIONS

❑ AUTOINJECTOR
❑ PEN
❑ PREFILLED SYRINGE
❑ VIAL

QUANTITY: **REFILLS:**

MAINTENANCE

STRENGTH:

SIG/DIRECTIONS

❑ AUTOINJECTOR
❑ PEN
❑ PREFILLED SYRINGE
❑ VIAL

QUANTITY: **REFILLS:**

QUANTITY: **REFILLS:**

Start of Therapy Date:

Special Delivery Instructions:

PHYSICIAN INFORMATION

Injection Training: ☐ Office to Instruct ☐ SP to Arrange Teaching

Prescriber Name:	Phone:	Fax:
Office Contact/Faxed By:	Email:	
NPI#:	TAX ID#:	Ship To: ❑ Patient ❑ MD Office 1st Order Only ❑ MD Office All Orders
Prescriber Signature	Date:	

❑ Dispense as written

Your signature authorizes the pharmacy to act on your behalf to obtain prior authorization for the prescribed medications. We will also pursue available copay and financial assistance on behalf of your patients.

This prescription is valid only if transmitted by facsimile machine by a licensed prescriber.