EVENTUS RX
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P 866-249-2696

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Dermatology Specialty Drug Referral Form

Patient full name:_______________________DOB:______________SSN:___________________

Phone:__________________________Sex:_______Height:____________Weight:____________

Address:____________________City:_______________State:_________Zip:_______________

Diagnosis:_____________________________Dx date or years with condition:______________

Secondary Dx:____

PPD Test clear?:____________Hepatitis B test clear?____________________________________

Prior treatments for Dx:____

Extent of disease as % of BSA________Primary location(s):_____________________________

Prescription

- ☐ Cosentyx #___ ☐150mg ☐300mg ☐Pen ☐Prefilled syr Sig:_________________________
- ☐ Dupixent #___ ☐300mg/2ml syr Sig:____
- ☐ Enbrel #___ ☐50mg/ml syr ☐50mg/ml Sureclick ☐25mg/ml syr Sig:____________________
- ☐ Humira #___ ☐20mg syr ☐40mg syr ☐40mg pen ☐40mg kit ☐40mg Starter kit
  Sig:____
- ☐ Otezla #___ ☐30mg starter pack ☐30mg tablet Sig:__________________________________
- ☐ Siliq #___ ☐210 mg prefilled syr Sig:____
- ☐ Stelara #___ ☐45mg syr ☐90mg syr Sig:____
- ☐ Taltz #___ ☐80mg/ml Autoinjector ☐80mg/ml syr Sig:_______________________________
- ☐ Tremfya #___ ☐100mg/ml syr Sig:____
- ☐ Valchlor #___ ☐0.016% gel Sig:____
- ☐ Remicade #___ ☐5mg/kg IV every ____ weeks ☐Alternate sig:_____________________________
- ☐ Inflectra #___ ☐5mg/kg IV every ____ weeks ☐Alternate sig:_____________________________
- ☐ Gengraf #___ ☐1.25mg/kg PO BID ☐Alternate sig:_____________________________

Total refills for selected RX ___________

Prescriber Name__________________________________Address_____________________________

Dea#________________________NPI_______________________Phone________________________

Signature____Date_____________________