



# Dermatology Referral Form

BIOMED Pharmaceuticals

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Corporate Office  
1512 8th Ave. Suite 100  
Fort Worth, TX 76104

Desoto  
2727 Bolton Boone Dr. Ste 110  
Desoto, TX 75115

Houston  
1919 N. Loop West, Ste 180  
Houston, TX 77008

Tyler  
837 S. Fleishel  
Tyler, TX 75701

San Antonio  
211 North San Saba, Suite 205  
San Antonio, TX 78207

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Allergies: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

Primary Insurance: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_

Phone #: \_\_\_\_\_

Phone#: \_\_\_\_\_

Subscriber: \_\_\_\_\_ DOB: \_\_\_\_\_

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ID#: \_\_\_\_\_ Policy/Group#: \_\_\_\_\_

ID#: \_\_\_\_\_ Policy/Group#: \_\_\_\_\_

Prescription Drug Card \_\_\_\_\_ Number \_\_\_\_\_

### Statement of Medical Necessity

#### Diagnosis:

- \_\_\_ Pemphigus Vulgaris (694.4)
- \_\_\_ Pemphigus Foliaceus (694.4)
- \_\_\_ Bullous Pemphigoid (694.5)
- \_\_\_ Other (specify ICD-9) \_\_\_\_\_

- \_\_\_ Epidermolysis Bullosa Acquisita (694.8)
- \_\_\_ Psoriasis (690.0)
- \_\_\_ Dermatomyositis (710.3)
- \_\_\_ Mucous Membrane Pemphigoid (694.60) with ocular involvement (694.61)
- \_\_\_ Atopic Dermatitis (691.8)
- \_\_\_ Psoriatic Arthritis (696.0)

Weight \_\_\_\_\_ (lbs) \_\_\_\_\_ (kg)

Allergies: \_\_\_\_\_

Medications: \_\_\_NO \_\_\_YES (please explain) \_\_\_\_\_

### Prescription: good for one year unless otherwise specified under special instructions.

\_\_\_ IVIG \_\_\_\_\_ Dosage \_\_\_\_\_ Frequency \_\_\_\_\_ Flush 5ml NS or D5 as indicated by brand before and after infusion

\_\_\_ Humira Dosage 40mg Syringe

\_\_\_ Enbrel 25mg and Sterile Water for injection and related supplies (given SQ) \_\_\_\_\_ Frequency

\_\_\_ Enbrel 50mg pre-filled syringe (given SQ) \_\_\_\_\_ Frequency

\_\_\_ Amevive \_\_\_\_\_ Dosage \_\_\_\_\_ Frequency \_\_\_\_\_ Sterile Water for injection (given IM)

\_\_\_ Other \_\_\_\_\_ TB test

Injection Training at Physician's Office

Special Instructions \_\_\_\_\_

**Physician Certification:** I certify the above therapy is medically necessary for 1 year, and the information is accurate to the best of my knowledge.

Signature: \_\_\_\_\_ Date \_\_\_\_\_ NPI# \_\_\_\_\_

Print Name: \_\_\_\_\_ DEA# \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ **Thank you for your referral.**



**Please send front and back copy of all insurance cards with referral.**