# Dermatology Referral Form

**Fax completed form to: 833-908-1122**

amerita specialty infusion services | Ivy Specialty Infusion an amerita company | mosaic infusion solutions an amerita company

## PATIENT INFORMATION

| | | |
|---|---|---|
| Patient Name: | Date of Birth: | Referral Date: |
| Address: | City/State/Zip: | |
| Home Phone: | Cell Phone: | Work Phone: |
| Secondary Contact: | Height: Weight: | ☐ Male ☐ Female |
| Patient Diagnosis & ICD-10: | | |
| Allergies: | | |

## PROVIDER INFORMATION

| | | |
|---|---|---|
| Physician Name: | Lic.#: | DEA #: |
| Practice Name: | | NPI#: |
| Address: | | City/State/Zip: |
| Office Contact: | Phone: | Fax: |
| Supervisory Physician (if applicable): | | |

## PLEASE ATTACH

- ☐ Patient demographics & front/back copy of all insurance cards (prescription & medical)
- ☐ Recent office visit notes, history & physical, lab & pertinent procedure results
- ☐ Current medication list & list of prior medications tried and failed (with dates)
- ☐ TB lab results within last 12 months *(Stelara, Simponi Aria, Ilumya & Infliximabs only)*
- ☐ HBV lab results within last 12 months *(Infliximabs & Simponi Aria only)*
- ☐ Letter of medical necessity if drug dosing or indication is outside of FDA guidelines

## NURSING & LAB ORDERS

**Nurse Orders:** Nurse to provide assessment, teaching, lab draws, medication administration and vascular access device insertion and/or management per physician orders.

**Flush Orders:** *NaCl 0.9%* - 5-10mL flush pre and post infusion and as needed *Heparin* - ☐ 10units/mL ***---OR---*** ☐100units/mL - 3-5mL flush after post-infusion NS flush if indicated to maintain line

**Lab Orders:** **Lab Date & Frequency:**

## PRESCRIPTION ORDERS

**Anaphylaxis Kit:** (Check all that apply)
☐ Epinephrine 0.3mg IM as needed ☐ Solu-cortef 250mg-500mg IV as needed ☐ Solu-Medrol 60mg - 125mg IV as needed
☐ Diphenhydramine _____ mg IV as needed ☐ NS Hydration 500 ml IV over 30 minutes as needed ☐ Other

**Pre-Medications:** (Check all that apply)
☐ Acetaminophen _____mg PO _____ minutes prior to infusion ☐ Solu-Medrol _____mg IV ____minutes prior to infusion
☐ Diphenhydramine _____ mg ☐ PO ***---OR---*** ☐ IV infusion _____minutes prior to infusion ☐ Other

**Supply Orders:** All supplies for vascular access line care, drug administration kit(s), pump, and IV pole will be provided as necessary

| PRODUCT | PRESCRIPTION INFORMATION | REFILLS |
|---|---|---|
| Is this a first dose? ☐ Yes ☐ No If No, when was last dose given?_____ When is patient due for next dose?_____ | | |
| ☐ ILUMYA | 100mg SC injection at 0 and 4 weeks then every 12 weeks | _____ |
| ☐ INFLIXIMAB<br>☐ Avsola<br>☐ Inflectra<br>☐ Remicade<br>☐ Renflexis | ☐ **Induction**: _____mg/kg or _____mg IV infusion via ☐ gravity ***---OR---*** ☐ pump over at least 2 hours at weeks 0, 2, and 6 | NONE |
| | ☐ **Maintenance**: _____mg/kg _____ mg IV infusion via ☐ gravity ***---OR---*** ☐ pump over at least 2 hours every _____ weeks<br>*(Note: Round to nearest 100mg for Medicaid patients)*<br>If Remicade infusion tolerated, adjust infusion time according to manufacturer package insert. | _____ |
| ☐ SIMPONI ARIA | 2 mg/kg IV infusion via ☐ gravity ***---OR---*** ☐ pump over 30 minutes at weeks 0 and 4, and every 8 weeks thereafter | _____ |
| ☐ SPEVIGO | ☐ 900 mg IV infusion over 90 minutes ☐ Additional 900 mg IV infusion over 90 minutes one week after initial dose if flare symptoms persist | _____ |
| ☐ STELARA | **Psoriasis Adult Subcutaneous**<br>☐ For patients <= 100 kg, 45 mg SC injection initially and 4 weeks later, followed by 45 mg every 12 weeks<br>☐ For patients > 100 kg, 90 mg SC injection initially and 4 weeks later, followed by 90 mg every 12 weeks | _____ |
| | **Psoriasis Pediatric Patients 6 to 17 (based on weight at time of initial dose)**<br>☐ For patients <= 60 kg, 0.75 mg/kg SC injection initially and 4 weeks later, then every 12 weeks<br>☐ For patients 60 kg – 100kg, 45 mg SC injection initially and 4 weeks later, then every 12 weeks<br>☐ For patients >100kg, 90 mg SC injection initially and 4 weeks later, then every 12 weeks | _____ |
| | **Psoriatic Arthritis Adult**<br>☐ 45 mg SC injection initially and 4 weeks later, followed by 45 mg SC injection every 12 weeks<br>☐ For patients with co-existent moderate-to-severe plaque psoriasis weighing >100 kg, 90 mg SC injection initially and 4 weeks later, then every 12 weeks | _____ |
| ☐ SKYRIZI | ☐ **Induction**: 600mg IV infusion via ☐ gravity ***---OR---*** ☐ pump over one hour at week 0, 4, and 8 | NONE |
| | ☐ **Maintenance**: 360mg SC injection at Week 12, and every 8 weeks thereafter | _____ |
| ☐ XOLAIR | ☐ 150 or ☐ 300 mg SC injection once every 4 weeks | _____ |
| ☐ IG | ***For Immunoglobulin therapy please refer to Immunoglobulin Form*** | |
| ☐ OTHER | | _____ |

***By signing this form and utilizing our services, you are authorizing Amerita to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.***

**Prescriber's Signature** **Print Name** **Date**
**Dispense as Written**

**Prescriber's Signature** **Print Name** **Date**
**Substitution Permitted**