Dermatology Referral Form





Fax completed form to:

| Patent Name Date of Bink Referent Date: Stores Thoma: CollPhone: Gol/State/Zay Stores Protoc: CollPhone: Work Phone: Stores Protoc: Male Female Patent Rame: LLK: DAte: Practice Name: Write Male Office Cartact Phone: Sax Supervisory Physician (FargeRead) Fargeread Sax Supervisory Physician (FargeRead) Table number of the source of the sour | PATIENT INFORMATION | | | | |
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| Hune Phone Cell Phone Work Phone Scendary Gratch Height Weight Male Female Allergie: PROVIDER INFORMATION Protected ware Protected ware Difference | Patient Name: | Date of Birth: | Referral Date: | | |
| Secondary Contract: Height: Weight: Male Fenale Attender Diggensite & (CD-1b: | Address: | City/State/Zip: | | | |
| Proceedings PROVIDER INFORMATION Physican Name: U.S.* D6A ± Protice Name: U.S.* D6A ± Address: Org/Statu/2p: Offers. Offers Contact: Phone: Face Supervisory Physician (if applicable): Face Face Patient demographics & front/back copy of all insurance cards (precorption & method) TB bareads within hast 12 months (Differings Simpon Arie, Ilumys & Inthinness only) Reset of fifes with rates, history & physical, like & perturner procedure results TB bareads within hast 12 months (Differings & Simpon Arie, Ilumys & Inthinness only) Reset of fifes with rates, history & physical, like & perturner procedure results TB bareads within hast 12 months (Differings & Simpon Arie, Ilumys & Inthian St Data fife with rates), history & fife with rates history & physical, like & perturner processory (Pace Simpon Arie, Ilumys & Inthian St Data fife with rates), which are applicable in the source of the s | Home Phone: | Cell Phone: | Work Phone: | | |
| PROVIDER INFORMATION Physican Name: LL2: DFA+: Practice Name: LL2: DFA+: Practice Name: LL2: DFA+: Practice Name: LL2: DFA+: Supervisory Physican (if applicable): Plan: fac: Pattert demographics & firmt/back copy of all insurance cards (prescription & medical) TB bla results within last 12 constris (Defan, Simpon Aria, Junry & Amiliando s andy) Event office of these, history & physical, Bds perticem proceedure results TB bla results within last 2 constrib, (Indianado & Simpon Aria, Junry & Amiliando and Simpon Aria, Junry & Amiliando Amiliando and Simpon Aria, Junry & Amiliando Amiliando Amilian Junry Amiliando Amiliando Amilian Amilian Junry Amiliando Amilian | Secondary Contact: | Height: Weight: | Male Female | | |
| PROVIDER INFORMATION Physicin Name: LLA: DFA:: Protectic Name: IRP:: IRP:: Address: Gity/State/Zp; Gity/State/Zp; Office Contact: Phone: Gas: Supervisory Physician (if applicable): Platent demographics & from/Dack copy of all insurance cards (prescription & medical) TB lab neutity subtin list 12 months (Stetors, Simpori Aris, Jumys & Milliondes only) Recent office with notes, history & physical, lab & periment procedure results TB lab neutity subtin list 12 months (Indinatande State) NURS/INC & LAB OR DERS: Nurse Orders: Nor Co Pwo-5 -10mL (heah per and post infusion and as needed / Appator : Donatis/mill-2-mol Donatis/mill-2-mol Hab Orders: Nor Co Pwo-5 -10mL (heah per and post infusion and as needed / Appator : Donatis/mill-2-mol Donatis/mill-2-mol Hab Orders: Nor Co Pwo -5 -10mL (heah per and post infusion and as needed / Appator : Donatis/mill-2-mol Donatis/mill-2-mol Hab Orders: Nor Co Pwo -5 -10mL (heah per and post infusion and as needed / Appator : Donatis/mill-2-mol Donatis/mill-2-mol Ket Co Media: Nor Co Pwo -5 -10mL (heah per and post infusion and as needed / Appator : Donatis/mill-2-mol Donatis/mill-2-mol Ket Addres: Epinephrine 0.3mg IM as needed | Patient Diagnosis & ICD-10: | | | | |
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| Address: Otypicate Zp; Office Cantact: Phone: Fax: Separation: Physician (If applicable): PLEASE ATTACH Patient demographics & fortuback copy of all insurance cask (prescription & medical) TB lab results within last 12 months; (Stelars, Simpon Aria, Jumps & Inflaindos any) Height demographics & fortuback copy of all insurance cask (prescription & medical insurance and procedure results Letter of medical necessity if drug dosing or inflaction is outside of FDA guidelines. Nurse Orders: Nurse to provide assessment, traching, lab daws, medication administration and vascular access dive insertion and/or management per physician orders. NURSING & LAB ORDERS Namebridge Status (Stt: Epinephrine 0.3mg Ma needed Solu-creft 250mg 500mg V3 meeded Solu-Medrol 60mg - 125mg W as needed Other: Diplenthydramine mg N 0 minutes point to infiscion Other Prev Medicationse: Actaminophen mg N 2 meeded Other Solu-Medrol 60mg - 125mg W as needed Diplenthydramine mg N 0 minutes point to infiscion Other Solu-Medrol 60mg - 125mg W as needed Difficult apply Diplenthydramine mg N 0 minutes point to infiscion Other Supply Orders: Norola Solu-Medr | Physician Name: | Lic.#: DEA #: | | | |
| Office Grantst: Prome: Fac Supervisory Physician (if applicable): PLEASE ATTACH Retent ofter wish notes, Status and the pertinent procedure results TB lab results within last 12 months (Sedara, Simpon / <i>Mag, Jump & Enformabs anti)</i> Retent office wish notes, listary & physical, lab & pertinent procedure results TB lab results within last 12 months (Sedara, Simpon / <i>Mag, Jump & Enformabs anti)</i> Hell Viab results within last 12 months (Sedara, Simpon / <i>Mag, Jump & Enformabs anti)</i> Hell Viab results within last 12 months (Sedara, Simpon / <i>Mag, Jump & Enformabs anti)</i> Hell Viab results within last 12 months (Sedara, Simpon / <i>Mag, Jump & Enformabs anti)</i> Hell Viab results within last 12 months (Sedara, Simpon / <i>Mag, Jump & Enformabs anti)</i> Hell Viab results within last 12 months (Sedara, Simpon / <i>Mag, Jump & Enformabs anti)</i> Hell Viab results within last 12 months (Sedara, Simpon / <i>Mag, Jump & Enformabs anti)</i> Hell Viab results within last 12 months (Sedara, Simpon / <i>Mag, Jump & Enformabs anti)</i> Hell Viab results within last 12 months (Sedara, Simpon / <i>Mag, Jump & Enformabs anti)</i> Hash Orders: Nucle Provide assessment, teaching, lab draws, medication and wism status accurates access device institution of the Simple Assessment, teaching, lab draws, medication and vian status access access device institution of the Simple Assessment, teaching, lab draws, medication and via status accurates access antip antip Assessment, teaching, lab draws, medication and vian status access antip antip Assestatus acceret Assessment, teaching, lab draws, medicate on statu | Practice Name: | NPI#: | | | |
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| Becent office visit notes, history & physical, lab & pertinent procedure results HBV lab results within lass 12 months (<i>lufkinnabs & Simpori Aria only</i>) Letter of medical necessity if dug dosing or indication is outside of FDA guidelines NURSE to provide assessment, teaching, lab draws, medication administration and vascular access device insertion and/or management per physician orders. Ruse to provide assessment, teaching, lab draws, medication administration and vascular access device insertion and/or management per physician orders. Ruse to provide assessment, teaching, lab draws, medication administration and vascular access device insertion and/or management per physician orders. Ruse to provide assessment, teaching, lab draws, medication administration and vascular access device insertion and/or management per physician orders. Reset interview in | PLEASE ATTACH | | | | |
| Current medication list & list of prior medications tried and failed (with dates) Letter of medical necessity if drug dosing or indication is outside of FDA guidelines Nurse Orders: Nurse to provide assessment, teaching, lab draw, medication administration and vascular access device insertion and/or management per physician orders. Hursh Orders: Nurse to provide assessment, teaching, lab draw, medication administration and vascular access device insertion and/or management per physician orders. Hush Orders: Nurse to provide assessment, teaching, lab draw, medication administration and vascular access device insertion and/or management per physician orders. Apalylaxis Kit: Epinephrine 0.3mg IM as needed Solu: vorte? Solu: Medrol OND PERS Anaphylaxis Kit: Epinephrine 0.3mg IM as needed Solu: vorte? Solu: Medrol OND PERS Supply Orders: M supplies for vascular access line care, drug administration Mit(s), pump, and IV pole volide as necessary PRESCRIPTION INFORMATION REFILLS Bits a first doe? Ve No. If Mount and Yueks then every 12 weeks murst period or next doe? UMW/M Itoomg Si njection at 0 and 4 weeks then every 12 weeks murst period or next doe? Monte Marcetaneeus Marcetaneeus Monte Monte Monte SMDOW Mark Itoo and a gravity - OR- pump over at least 2 hours are weels 0, 2, and 6 NONE | Patient demographics & front/back copy of all insurance cards (prescription & medical) TB lab results within last 12 months (Stelara, Simponi Aria, Ilumya & Infliximabs only) | | | | |
| NURSING & LAB ORDERS Nurse Orders: Nurse to provide assessment, texhing, lab draws, medication administration and vacular access device insertion and/or management per physician orders. Hush Orders: No20.29% -5-10m. flush pre and post infusion and as needed Heparin- Douints/mL -3-5mL flush after post-infusion NS flush if indicated to maintain line Lab Orders: PRESCRIPTION ORDERS Anaphylaxis Kit: Epinephrine 0.3mg IV as needed SoluNeedrol 60mg - 125mg IV as needed Others: Meridian Depine 0.3mg IV as needed SoluNeedrol 60mg - 125mg IV as needed Other Pre-Medications: Anaphylaxis Kit: Epinephrine 0.3mg IV as needed Not-Medrol | Recent office visit n | Recent office visit notes, history & physical, lab & pertinent procedure results HBV lab results within last 12 months (Infliximabs & Simponi Aria only) | | | |
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| Hush Orders: Na/00.9% - 5-10mL flush pre and post infusion and as needed Heap interval 100 units/mLOR- 100 units/mLOR- 100 units/mLSmL flush after post-infusion NS flush if indicated to maintain line Lab Orders: Lab Date & Frequency: Lab Date & Frequency: PRESCRIPTION ORDERS Anaphylaxis Kit: Epinephrine 0.3mg IM as needed Solu- order // SompOmg // Wa sneeded Solu-Medrol // Wa sneeded Check all that apply Diphenhydramine mg IV as needed NS Hydration .500 ml IV over 30 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 PRESCRIPTION INFORMATION REFILLS ILUMMA 100 mg SC injection at 0 and 4 weeks then every 12 weeks Men is patient due for next dose? ILUMMA Induction: mg Ng mg // mg N infusion via gravityOR- pump over at least 2 hours at weeks 0, 2, and 6 NONE Mintenance: mg Ng mg // mg N infusion via gravityOR- pump over at least 2 hours at weeks 0, 2, and 6 NONE Mintenance: mg Ng mg M infusion via gravityOR- pump over at least 2 hours at weeks 0, 2, and 6 NONE Movia Maintenance: mg Ng mg M infusion over 90 minutes at weeks 0 and 4, and eve | | | | | |
| Hush Orders: Na/00.9% - 5-10mL flush pre and post infusion and as needed Heap interval 100 units/mLOR- 100 units/mLOR- 100 units/mLSmL flush after post-infusion NS flush if indicated to maintain line Lab Orders: Lab Date & Frequency: Lab Date & Frequency: PRESCRIPTION ORDERS Anaphylaxis Kit: Epinephrine 0.3mg IM as needed Solu- order // SompOmg // Wa sneeded Solu-Medrol // Wa sneeded Check all that apply Diphenhydramine mg IV as needed NS Hydration .500 ml IV over 30 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 PRESCRIPTION INFORMATION REFILLS ILUMMA 100 mg SC injection at 0 and 4 weeks then every 12 weeks Men is patient due for next dose? ILUMMA Induction: mg Ng mg // mg N infusion via gravityOR- pump over at least 2 hours at weeks 0, 2, and 6 NONE Mintenance: mg Ng mg // mg N infusion via gravityOR- pump over at least 2 hours at weeks 0, 2, and 6 NONE Mintenance: mg Ng mg M infusion via gravityOR- pump over at least 2 hours at weeks 0, 2, and 6 NONE Movia Maintenance: mg Ng mg M infusion over 90 minutes at weeks 0 and 4, and eve | Nurse Orders: Nurse to provide assessment, teaching, lab draws, medication administration and vascular access device insertion and/or management per physician orders. | | | | |
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| Anaphylaxis Kit: Epinephrine 0.3 mg IM as needed Solu-cortef 250mg-500 mg IV as needed Solu-Medrol 60mg - 125 mg IV as needed (Check all that apply) Diphenhydramine mg IV as needed Other Pre-Medications: Acetaminophen mg IV as needed NB Hydration 500 m IV over 30 minutes as needed Other Pre-Medications: Acetaminophen mg IV | | | | | |
| (Check all that apply) Diphenhydramine mg IV as needed NS Hydration 500 ml IV over 30 minutes as needed Other Pre-Medications: Acetaminophen mg PO minutes prior to infusion minutes prior to infusion Supply Orders: Bupple for vascular access line care, drug administration kt(s), pump, and IV pole will be provided as necessary PRESCRIPTION INFORMATION REFILLS Is this a first dose? Yes No If No, when was last dose given? When is patient due for next dose? | PRESCRIPTION ORDERS | | | | |
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| Supply Orders: All supplies for vascular access line care, drug administration kit(s), pump, and IV pole will be provided as necessary REFILLS Is this a first dose? Yes No If No, when was last dose given? When is patient due for next dose? REFILLS ILUMYA 100mg 25 clinection and 4 weeks then every 12 weeks | | | | | |
| PRODUCT PRESCRIPTION INFORMATION REFILLS isthis a first dos? Yes No If No, when was last dose given? When is patient due for next dose? | | | | | |
| 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 | | | | REFILLS | |
| ILUMYA 100mg SC injection at 0 and 4 weeks then every 12 weeks | | | | | |
| Avsola Maintenance:mg/kgmg V infusion via gravityOR pump over at least 2 hours everyweeks | ILUMYA | | | | |
| Avsola Maintenance:mg/kgmg V infusion via gravityOR pump over at least 2 hours everyweeks | INFLIXIMAB | | t 2 hours at weeks 0, 2, and 6 | NONE | |
| Inflectra (Note: Round to nearest 100mg for Medicaid patients) | Avsola | st 2 hours every weeks | | | |
| Remicade Renflexis If Remicade infusion tolerated, adjust infusion time according to manufacturer package insert. SIMPONI ARIA 2 mg/kg IV infusion via gravityOR pump over 30 minutes at weeks 0 and 4, and every 8 weeks thereafter | Inflectra | | | | |
| Internation 2 mg/kg IV infusion via gravityOR 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 | | | | | |
| For patients <= 100 kg, 45 mg SC injection initially and 4 weeks later, followed by 45 mg every 12 weeks | | | | | |
| For patients > 100 kg, 90 mg SC injection initially and 4 weeks later, followed by 90 mg every 12 weeks | STELARA | | | | |
| STELARA Psoriasis Pediatric Patients 6 to 17 (based on weight at time of initial dose) For patients <= 60 kg, 0.75 mg/kg SC injection initially and 4 weeks later, then every 12 weeks | | | | | |
| STELARA For patients <= 60 kg, 0.75 mg/kg SC injection initially and 4 weeks later, then every 12 weeks | | | | | |
| For patients 60 kg – 100kg, 45 mg SC injection initially and 4 weeks later, then every 12 weeks | | For patients <= 60 kg, 0.75 mg/kg SC injection initially and 4 weeks later, then every 12 weeks | | | |
| Psoriatic Arthritis Adult Psoriatic Arthritis Adult 45 mg SC injection initially and 4 weeks later, followed by 45 mg SC injection every 12 weeks | | | | | |
| 45 mg SC injection initially and 4 weeks later, followed by 45 mg SC injection every 12 weeks | | | | | |
| 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 | | | | | |
| 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 | | | nitially and 4 weeks later then every 12 weeks | | |
| SKYRIZI Maintenance: 360mg SC injection at Week 12, and every 8 weeks thereafter | SKYRIZI | | | NONE | |
| XOLAIR 150 or 300 mg SC injection once every 4 weeks | | | | | |
| IG For Immunoglobulin therapy please refer to Immunoglobulin Form OTHER | XOLAIR | | | | |
| 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. | | | | | |
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Prescriber's Signature Dispense as Written Print Name

Date

Prescriber's Signature Substitution Permitted Print Name

Date





