



| Dermatology Referral Forn | r |
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| Fax completed form to: 833-908-1122 | |

| Police Tomos: Get Phane: Gay State/Ture | PATIENT INFORMATION | | | | | | | | |
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| Secondary Commark: Beight: Weight: Weight: Male Fernale | Address: | | | City/State/Zip | | | | | |
| Playsian Name: Physician Name: Dic.#: DA #: DA # | Home Phone: | Cell Pho | ne: | | Work Phone: | | | | |
| Physician Name | Secondary Contact: | Height: | Weight: | | Male Female | | | | |
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| Precision Examples Office Contract: Phone: Precision Examples (if applicable): Precision Contract: Precision (if applicable): Precision | | | | | | | | | |
| Address: Office Contact: Phone: Phone: Phone: PLEASE ATTACH Patient demographics & front/back copy of all insurance cards (prescription & medical) Recent office vists notes, listory & physical, lab & pertinent procedure results Current medication list & list of prior medications tried and failed (with date) Letter of medical necessity if drug dosing or indication is outside of FDA guidelines **NURSING & LAB ORDERS** **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: Nurd O.9% - 5-10mt, flush pre and post infusion and as needed **Hepatin** - Dounts: Nurse orders: Nurd O.9% - 5-10mt, flush pre and post infusion and as needed **Hepatin** - Dounts: Nurse orders: Nurd O.9% - 5-10mt, flush pre and post infusion and as needed **Hepatin** - Dounts: Nurse orders: Nurd O.9% - 5-10mt, flush pre and post infusion and as needed **Hepatin** - Dounts: Nurse orders: Nurd O.9% - 5-10mt, flush pre and post infusion and as needed **Hepatin** - Dounts: Nurse orders: Nurd O.9% - 5-10mt, flush pre and post infusion and as needed **Hepatin** - Dounts: Nurse orders: Nurd O.9% - 5-10mt, flush pre and post infusion and as needed **Hepatin** - Dounts: Nurse orders: Nurd O.9% - 5-10mt, flush pre and post infusion and as needed **Hepatin** - Dounts: Nurse orders: Nurse | Physician Name: | Lic.#: | | DEA #: | | | | | |
| Office Contact: | Practice Name: | | | NPI#: | | | | | |
| Patient demographics & Front/back copy of all insurance cards (prescription & medical) Recent office visit notes, bistory & physical, lab & pertinent procedure results Tellah results within last 12 months (Stelanz, Simponi Aria, Jiumya & Infliximabs only) | Address: | City/State/Zip: | | | | | | | |
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| Lab Date & Frequency: PRESCRIPTION ORDERS | | | | | | d to maintain line | | | |
| Anaphylaxis Kit: Epinephrine 0.3mg IM as needed Solu-cortef 250mg-500mg IV as needed Other Other Diphenhydramine mg IV as needed MS Hydration 500 ml IV over 30 minutes as needed Other Other Pre-Medications: Actaminophen mg IV a minutes prior to infusion Solu-Medrol mg IV minutes prior to infusion Other Supply Orders; All supplies for vascular access line care, drug administration ktt(3), pump, and IV pole will be provided as necessary PRODUCT Supply Orders; All supplies for vascular access line care, drug administration ktt(3), pump, and IV pole will be provided as necessary PRODUCT Supply Orders; All supplies for vascular access line care, drug administration ktt(3), 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? ILUMYA 100mg SC injection at 0 and 4 weeks dree nevery 12 weeks Inflectra Remicade Renflects Remicade Renflects Remicade infusion tolerated, adjust infusion in image according to manufacturer package insert. Maintenance: _mg/kgmg IV infusion wiagravity —OR— pump over at least 2 hours everyweeks | | 70 - 5- Torric riusir pre and post irrusion and as needed | | | nusir arter post-infusion No husir ii indicate | a to maintain inte | | | |
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| Check all that apply 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 PRESCRIPTION INFORMATION REFILLS | | | • | | • | | | | |
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| For patients 60 kg — 100kg, 45 mg SC injection initially and 4 weeks later, then every 12 weeks For patients > 100kg, 90 mg SC injection initially and 4 weeks later, then every 12 weeks Psoriatic Arthritis Adult 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 gravityOR pump over one hour at week 0, 4, and 8 NONE | | | | Lucales | | | | | |
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| Psoriatic Arthritis Adult 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 gravityOR pump over one hour at week 0, 4, and 8 NONE | | | | | | | | | |
| 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 gravityOR pump over one hour at week 0, 4, and 8 NONE | | | Treels lately aren every 12 meets | · | | | | | |
| 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 gravityOR pump over one hour at week 0, 4, and 8 NONE | | | | | | | | | |
| Maintenance: 360mg SC injection at Week 12, and every 8 weeks thereafter | | | | | y and 4 weeks later, then every 12 weeks | | | | |
| XOLAIR 150 or 300 mg SC injection once every 4 weeks IG For Immunoglobulin therapy please refer to Immunoglobulin Form OTHER | CVVDI7I | Induction: 600mg IV infusion via gravity | OR pump over one hour at wee | ek 0, 4, and 8 | | NONE | | | |
| IG For Immunoglobulin therapy please refer to Immunoglobulin Form OTHER | או ו ווען | Maintenance: 360mg SC injection at Week 12, and every 8 weeks thereafter | | | | | | | |
| OTHER | | <u> </u> | | | | | | | |
| · · · · · · · · · · · · · · · · · · · | | For Immunoglobulin therapy please refer to Imm | unoglobulin Form | | | | | | |
| 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. | | | | | | | | | |
| | By signing this fo | orm and utilizing our services, you are authorizing Ame | rita to serve as your prior authorizatio | n designated agent in de | ealing with medical and prescription insura | nce companies. | | | |

Prescriber's Signature **Dispense as Written**

Print Name

Date

Prescriber's Signature **Substitution Permitted**

Print Name

Date





