

Dermatology Referral Form

Fax completed form to: 833-908-1122



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)		TB lab results within last 12 months (<i>Stelara, Simponi Aria, Ilumya & Infliximabs only</i>)	
Recent office visit notes, history & physical, lab & pertinent procedure results		HBV lab results within last 12 months (<i>Infliximabs & Simponi Aria only</i>)	
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	
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:	Epinephrine 0.3mg IM as needed	Solu-cortef 250mg-500mg IV as needed	Solu-Medrol 60mg - 125mg IV as needed
(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	Solu-Medrol _____ mg IV _____ minutes prior to infusion	
(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			
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 Avsola Inflixtra Remicade Renflexis	Induction: _____ mg/kg or _____ mg IV infusion via gravity ---OR--- pump over at least 2 hours at weeks 0, 2, and 6 Maintenance: _____ mg/kg _____ mg IV infusion via gravity ---OR--- pump over at least 2 hours every _____ weeks (Note: Round to nearest 100mg for Medicaid patients) If Remicade infusion tolerated, adjust infusion time according to manufacturer package insert.		NONE
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 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		_____
	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 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		_____
SKYRIZI	Induction: 600mg IV infusion via gravity ---OR--- pump over one hour at week 0, 4, and 8 Maintenance: 360mg SC injection at Week 12, and every 8 weeks thereafter		NONE
XOLAIR	150 or 300 mg SC injection once every 4 weeks		_____
IG	For Immunoglobulin therapy please refer to Immunoglobulin Form		_____
OTHER			_____
<i>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.</i>			

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

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

