## Dermatology Referral Form



an amerîta company

Fax Completed Form To:

Patient Name:

Secondary Contact:

Physician Name: Practice Name:

Patient Diagnosis & ICD-10:

Supervisory Physician (if applicable):

Address: Home Phone:

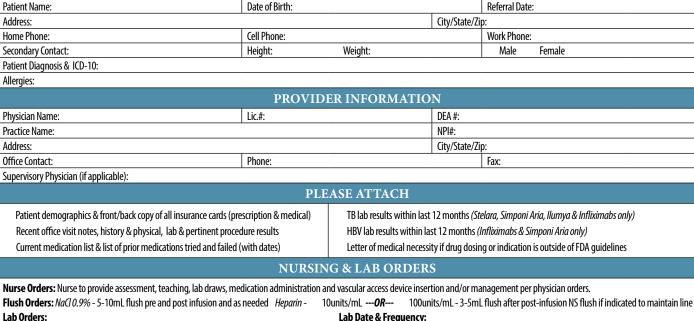
Allergies:

Address: Office Contact:

Lab Orders:

**Phone:** 

PATIENT INFORMATION



| Eus Viueisi                |  | Eus Dute a l'requeite)                           |                                       |  |  |
|----------------------------|--|--|---------------------------------------|--|--|
| 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:           | Acetaminophenmg POn  | ninutes prior to infusion Solu-Medrolmg IV _     | minutes prior to infusion             |  |  |
| (Check all that apply)     | Diphenhydramine mg PO <b>O</b>   | <b>R</b> IV infusionminutes prior to infusion    | Other                                 |  |  |
| Supply Orders: All supplie | 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 |  |
|--|---|---------|--|
| 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                                   | Induction:mg/kg ormg IV infusion via gravityOR pump over at least 2 hours at weeks 0, 2, and 6  | NONE    |  |
| Avsola<br>Inflectra<br>Remicade<br>Renflexis | Maintenance:   mg/kg   mg IV infusion via   gravityOR   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.   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   |         |  |
| 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   |         |  |
|  | 150 or 300 mg SC injection once every 4 weeks   |         |  |
| XOLAIR                                       |   |         |  |
| IG   | For Immunoglobulin therapy please refer to Immunoglobulin Form  |         |  |

**Prescriber's Signature Dispense as Written** 

Date

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







