

# Dermatology Referral Form

Fax Completed Form To:

Phone:



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 ( <i>Stelara, Simponi Aria, Ilumya &amp; Infliximabs only</i> ) HBV lab results within last 12 months ( <i>Infliximabs &amp; Simponi Aria only</i> ) Letter of medical necessity if drug dosing or indication is outside of FDA guidelines

NURSING & LAB ORDERS	
<b>Nurse Orders:</b> Nurse to provide assessment, teaching, lab draws, medication administration and vascular access device insertion and/or management per physician orders.	
<b>Flush Orders:</b> 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	
<b>Lab Orders:</b> <b>Lab Date &amp; Frequency:</b>	

PRESCRIPTION ORDERS			
<b>Anaphylaxis Kit:</b>	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 _____
<b>Pre-Medications:</b>	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 _____	
<b>Supply Orders:</b> 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	<b>Induction:</b> _____ mg/kg or _____ mg IV infusion via gravity ---OR--- pump over at least 2 hours at weeks 0, 2, and 6 <b>Maintenance:</b> _____ 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	<b>Psoriasis Adult Subcutaneous</b> 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	_____
	<b>Psoriasis Pediatric Patients 6 to 17 (based on weight at time of initial dose)</b> 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	_____
	<b>Psoriatic Arthritis Adult</b> 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	_____
XOLAIR	150 or 300 mg SC injection once every 4 weeks	_____
IG	<b>For Immunoglobulin therapy please refer to Immunoglobulin Form</b>	_____
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

