Dermatology Referral Form

Fax Completed Form To: **Phone:**

amerita
specialty infusion services

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 *(Stelara, Simponi Aria, Ilumya & Infliximabs only)*
- ☐ HBV lab results within last 12 months *(Infliximabs & Simponi Aria only)*
- ☐ 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: (Check all that apply)
☐ Epinephrine 0.3mg IM as needed ☐ Solu-cortef 250mg-500mg IV as needed ☐ Solu-Medrol 60mg - 125mg IV as needed
☐ Diphenhydramine _____ mg IV as needed ☐ NS Hydration 500 ml IV over 30 minutes as needed ☐ Other

Pre-Medications: (Check all that apply)
☐ Acetaminophen _____ mg PO _____ minutes prior to infusion ☐ Solu-Medrol _____ mg IV ____ minutes prior to infusion
☐ 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 ☐ Inflectra ☐ Remicade ☐ Renflexis	☐ **Induction**: _____ mg/kg or _____ mg IV infusion via ☐ gravity ***---OR---*** ☐ pump over at least 2 hours at weeks 0, 2, and 6	NONE
	☐ **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.	_____
☐ 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	_____
☐ XOLAIR	☐ 150 or ☐ 300 mg SC injection once every 4 weeks	_____
☐ IG	***For Immunoglobulin therapy please refer to Immunoglobulin Form***	
☐ 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

AME_DERMATOLOGY REFER 6.24

ameritaiv.com

ACHC ACCREDITED
PCAB ACCREDITED Compounding Pharmacy