

# Dermatology Referral Form

Fax Completed Form To: 833-433-7975



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 Inflextra 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		NONE
	<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.		
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	_____		_____
<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

