

Dermatology Order Form

Fax Completed Form To:

Phone:

PATIENT INFORMATION			
Patient Name:		Date of Birth:	
Address:		Referral Date:	
Home Phone:		City/State/Zip:	
Cell Phone:		Work Phone:	
Secondary Contact:		Height: Weight: ☐ Male ☐ Female	
Patient Diagnosis & ICD-10:			
Allergies:			
PROVIDER INFORMATION			
Physician Name:		Lic.#:	
Practice Name:		DEA #:	
Address:		NPI#:	
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 & Infliximabs only</i>) ☐ HBV lab results within last 12 months (<i>Infliximabs & Simponi Aria only</i>) ☐ 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 <i>(Note: Round to nearest 100mg for Medicaid patients)</i>		_____
☐ SIMPONI ARIA	2 mg/kg IV infusion via ☐ gravity ---OR--- ☐ pump over 30 minutes at weeks 0 and 4, and every 8 weeks thereafter 1. Initiation following IV treatment of active flare: 300mg SC starting 4 weeks after last IV dose then every 4 weeks 2. Initiation of therapy in patients w/o an active flare: 600mg SC as a loading dose at week 0, followed by 300mg SC at week 4 then every 4 weeks		_____
☐ 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		_____
☐ XOLAIR	☐ 150 or ☐ 300 mg SC injection once every 4 weeks		_____
☐ IG	For Immunoglobulin therapy please refer to Immunoglobulin Form		_____
☐ OTHER			_____

Prescriber's Signature
Dispense as Written

Print Name

Date

Prescriber's Signature
Substitution Permitted

Print Name

Date