US infusions

DERMATOLOGY ORDER SET

DERMATOLOGY ORDERS:

Patient Name: _____ DOB: _____ Phone:_____
Email:_____

☐ New to therapy ☐ Continuing therapy: next treatment date: _____.

MEDICAL INFORMATION:

☐ L50.1 - Chronic Idiopathic Urticaria

☐ M33.10 – Dermatomyositis ☐ M33.90 - Dermatopolymyositis

☐ L10.0 – Pemphigus vulgaris

☐ L40.50 - Psoriasis, arthropathic ☐ L40.0 - Psoriasis, plaque

☐ Other - _____

THERAPY ORDERS:

☐ ***Cimzia**: Dose: □ 200mg subcutaneously every 2 weeks □ 400mg subcutaneously every □ 2 weeks □ 4 weeks
□ 400mg subcutaneously at weeks 0, 2, and 4 followed by □ 200mg □ 400mg every 2 weeks

☐ **Ilumya**: Initial Dose: □ 100mg subcutaneously at weeks 0, 4, and every 12 weeks thereafter
Maintenance Dose: □ 100mg subcutaneously every 12 weeks Refills: □ 1yr □ Other: _____

☐ ***Infliximab:** Dose: _____mg/kg Frequency: □ Every _____ weeks **OR** □ 0, 2, 6, then every 8 weeks
Refills: □ 1yr □ Other: _____

☐ ***IVIG**: Dose: □ _____mg/kg **OR** □ _____gm/kg IV x_____ day(s) **OR** □ divided over _____ day(s)
Frequency: □ Every _____ weeks **OR** Other _____ Refills □ 1yr □ Other: _____

☐ **Xolair**: Dose: □ 150mg □ 300mg subcutaneously every 4 weeks Refills: □ 1yr □ Other: _____

☐ ***Rituximab:** Initial dose: □ 1000mg IV at day 0 and 15
Maintenance dose: □ 500mg IV at month 12 and every 6 months thereafter Refills: □ _____

☐ ***Simponi Aria:** □ Initial Dose: 2mg/kg at weeks 0,4, and then every 8 weeks
□ Maintenance Dose: 2mg/kg every 8 weeks Refills: □ 1yr □ Other: _____

☐ ***Stelara:** Initial Dose: □ 45mg subcutaneously initially, 4 weeks later, followed by 45mg every 12 weeks
□ 90mg subcutaneously initially, 4 weeks later, followed by 90mg every 12 weeks
Maintenance Dose: □ 45mg □ 90mg subcutaneously every 12 weeks Refills: □1yr □ Other: _____

***See opposite page for required pre-screening**

****PLEASE COMPLETE BOTH SIDES OF THIS FORM****

US infusions

DERMATOLOGY ORDER SET

DERMATOLOGY ORDERS:

Patient Name: _____ DOB: _____ Phone: _____

PREMEDICATION ORDERS:

☐ **Tylenol:** □ 500mg □ 1000mg by mouth
☐ **Antihistamine** (choose one): □ Cetirizine 10mg by mouth □ Diphenhydramine 25mg by mouth
□ Loratadine 10mg by mouth

☐ **Solu-Medrol** _____mg
☐ **Other:** _____

THERAPIES TRIED AND FAILED, INTOLERANCES, OR CONTRAINDICATIONS TO CONVENTIONAL THERAPY (e.g., azathioprine, corticosteroids, cyclophosphamide, methotrexate, mycophenolate):

_____

_

_____

REQUIRED PRE-SCREENING:

☐ TB screening test completed within 12 months w/attached □ *Positive □ Negative results
Required for: Cimzia, Ilumya, Infliximab, Simponi Aria, and Stelara
☐ Hepatitis B screening (surface antigen) w/attached □ *Positive □ Negative results
Required for: Cimzia, Infliximab, Rituximab, and Simponi Aria
☐ Hepatitis B core antibody total (not IgM) w/attached □ *Positive □ Negative results *Required for: Rituximab*
☐ Serum immunoglobulins w/attached results *Required for: Rituximab*
☐ Baseline creatinine w/attached results *Required for: IVIG*
*if TB or HepB results are positive attach documentation of treatment or medical clearance, and a negative CXR (TB+)

REQUIRED ASSOCIATED DOCUMENTATION:

☐ Patient demographics ☐ Front/back of all insurance cards ☐ Current medication list ☐ Labs and/or test results
☐ Include clinical notes supporting the above diagnoses.
☐ Include clinical notes supporting contraindication/intolerance, or failed trial of conventional therapy or biologic.
☐ *If applicable* - Last know biological therapy: _____ and last date received: _____.
☐ *If switching to biologic therapy* - please perform a wash-out period of _____ weeks prior to starting ordered biologic.

REFERRING PROVIDER INFORMATION:

Provider name: _____ Signature:_____ Date:_____

NPI: _____ Phone: _____ Fax: _____

FAX COMPLETED FORM TO US INFUSIONS AT 469-200-2606