

### Patient information

Patient name \_\_\_\_\_

DOB \_\_\_\_\_

Mobile number \_\_\_\_\_

Weight \_\_\_\_\_  kgs  lbs

Diagnosis  Psoriasis vulgaris  
 Other \_\_\_\_\_

Allergies  NKDA  \_\_\_\_\_

### Medication instructions

Pre-medications  N/A  
 Provider prescribed: \_\_\_\_\_

Medication order Dose Frequency  
 100 mg  Weeks 0, 4, then every 12 weeks  
 Other \_\_\_\_\_  Every 12 weeks  
 Other \_\_\_\_\_

Medication route  Subcutaneous injection  
 Other \_\_\_\_\_

Lab order (Include frequency) Please list any labs to be drawn by the infusion clinic:  
 N/A  
 \_\_\_\_\_

Prerequisites Please include the following with your fax submission: Labs and tests supporting diagnosis | Office / progress notes | Demographics | Negative TB test results

Please send to  Columbia, MD  Silver Spring, MD  Bowie, MD  Frederick, MD

### Referring provider information

Referring provider name \_\_\_\_\_ NPI \_\_\_\_\_

Practice name \_\_\_\_\_

Point of contact Name \_\_\_\_\_ Email \_\_\_\_\_ Phone \_\_\_\_\_

Provider signature \_\_\_\_\_ Date \_\_\_\_\_