DERMATOLOGY INFUSION ORDER FORM
P: 240.200.4464 F: 240.892.3005

PATIENT INFORMATION: Fax completed form, insurance information, and clinical documentation to 240.892.3005

Patient Name: _____ DOB: _____ Phone: _____

Patient Status: ☐New to Therapy ☐Continuing Therapy **Next Treatment Date:** _____

MEDICAL INFORMATION

Patient Weight: _____ lbs./kg. (required) Allergies: _____

THERAPY ORDER

Diagnosis	Medication Orders	Refills
☐ Dermatomyositis ☐ Polymyositis ☐ Pemphigoid/Pemphigus **ICD-10:** _____	**IVIg** Orders: _____ mg/kg **OR** _____ gm/kg IV x _____ day(s) **OR** divided over _____ days(s) **Frequency:** Every _____ weeks **OR** _____ Preferred brand: _____ (Active Infusions to choose if not indicated) Additional Ig orders: _____	☐ x 1 year ☐ _____
☐ CIU **ICD-10:** _____	**Xolair** ☐ 150mg SQ every 4 weeks **OR** ☐ 300mg SQ every 4 weeks **REQUIRED: Patient must have an EpiPen in their possession on their appointment date**	☐ x 1 year ☐ _____
☐ Pemphigus Vulgaris **ICD-10:** _____	☐ **Rituximab or rituximab biosimilar** (as required by patient's insurance) ☐ Do not substitute. Infuse the following rituximab product: _____ Initial Dose: ☐ 1000mg IV at day 0, 15 days Maintenance Dose: ☐ 500mg IV at month 12 and every 6 months thereafter Other dose: _____ **Protocol Premedication Orders: Solu-Medrol 100mg IV, Tylenol 1000mg PO, and Benadryl 50mg PO/IV**	☐ X 1 year ☐ _____
☐ Psoriatic Arthritis ☐ Psoriasis ☐ Plaque Psoriasis **ICD-10:** _____	☐ **Infliximab or infliximab biosimilar** (as required by patient's insurance) ☐ Do not substitute. Infuse the following infliximab product: _____ **Dose**: _____ mg/kg **Frequency**: ☐ Every _____ weeks **OR** ☐ 0, 2, 6, then every 8 weeks **Simponi Aria** Initial Dose: ☐ 2mg/kg IV at weeks 0, 4, and then every 8 weeks Maintenance Dose: ☐ 2mg/kg IV every 8 weeks **Stelara** ☐ 45mg SQ initially and 4 weeks later followed by 45mg SQ every 12 weeks (<100kg) ☐ 90mg SQ initially and 4 weeks later followed by 90mg SQ every 12 weeks (>100kg) Maintenance Dose: ☐ 45mg SQ every 12 weeks **OR** ☐ 90mg SQ every 12 weeks **Ilumya** Initial Dose: ☐ 100mg SQ at weeks 0, 4, and every 12 weeks thereafter Maintenance Dose: ☐ 100mg SQ every 12 weeks **Cimzia** ☐ 200mg SQ every 2 weeks **OR** ☐ 400mg SQ every 4 weeks **OR** ☐ 400mg SQ every 2 weeks ☐ 400mg SQ at weeks 0, 2, and 4 followed by: ☐ 200mg **OR** ☐ 400mg every 2 weeks	☐ x 1 year ☐ _____
☐ GPP **ICD-10:** _____	☐ **Spevigo** 900mg IV x 1 ☐ Repeat Spevigo 900mg IV in 1 week if symptoms persist	

Premedication orders: Tylenol ☐ 1000mg OR ☐ 500 mg PO
Please choose one antihistamine: ☐ Diphenhydramine 25mg PO ☐ Loratadine 10mg PO ☐ Cetirizine 10mg PO ☐ Other: _____
Additional premedications: ☐ Solu-Medrol _____ mg IVP ☐ Solu-Cortef _____ mg IVP ☐ Other:
_____

Please provide patient's demographic information, insurance information, medication list, and clinical notes. Active Infusions will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and assist them in enrolling in any available co-pay assistance programs as needed/applicable. Thank you for the referral.

PROVIDER INFORMATION

Provider Name: _____ Signature: _____ Date: _____

Provider NPI: _____ Phone: _____ Fax: _____ Contact Person: _____

ACTIVE infusions

COMPREHENSIVE SUPPORT FOR DERMATOLOGY THERAPY

P: 240-200-4464 F: 240-892-3005

PATIENT INFORMATION:

Patient Name: _____ DOB: _____

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING AND INSURANCE APPROVAL

- ☐ Include signed and completed order (MD/prescriber to complete previous page)
- ☐ Include patient demographic information and insurance information
- ☐ Include patient's mediation list
- ☐ Supporting clinical notes (H&P) to include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy
  - ☐ For biologic orders, has the patient had a documented contraindication/intolerance or failed trial of a conventional therapy (i.e., steroids)? ☐ Yes ☐ No
    If yes, which drug(s)? _____
  - ☐ For biologic orders, does the patient have a contraindication/intolerance or failed trial to any other biologic (i.e., Stelara, Cimzia)? ☐ Yes ☐ No
- ☐ Include labs and/or test results to support diagnosis (attach)
- ☐ *If applicable* – Last known biological therapy: _____ and last date received: _____.
  If patient is switching biologic therapies, please perform a wash out period of _____ weeks prior to starting ordered biologic therapy.
- ☐ Other medical necessity: _____

REQUIRED PRE-SCREENING (BASED ON DRUG THERAPY)

- ☐ **TB screening test completed within 12 months – attach results**
  Required for: Cimzia, Infliximab, Stelara, Ilumya, Simponi Aria, Spevigo
  ☐ **Positive** ☐ **Negative**
- ☐ **Hepatitis B screening test completed (Hepatitis B surface antigen) – attach results**
  Required for: Cimzia, Infliximab, Simponi Aria
  ☐ **Positive** ☐ **Negative**
- ☐ **Hepatitis B core antibody total (not IgM) -** ☐ **Positive** ☐ **Negative**
  Required for: Rituximab
- ☐ **Serum immunoglobulins – attach results** Recommended for: Rituximab
- ☐ **Baseline creatinine** Required for: IVIG

*If TB or Hepatitis B results are positive, please provide documentation of treatment or medical clearance and a negative CXR (TB+)

Please fax all information to 240-892-3005 or email to info@activeinfusions.com for assistance