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



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**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**



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# ACTIVE INFUSIONS | Patient Demographics Request

**Dear Provider / Office Staff,**

We have received a referral for the above patient and will be reaching out to begin the scheduling process. To ensure we are able to make contact in a timely manner, we kindly ask that your office confirm or complete the patient demographic information below. This helps us verify accurate contact details prior to outreach and avoid any delays in care.

**Please complete and return via fax to 240-892-3005 or email kendrick@activeinfusions.com. Thank you!**

## PATIENT CONTACT INFORMATION

*Please confirm or provide the most current contact information you have on file for this patient.*

**Patient Name**

*Last, First MI*

**Date of Birth**

*MM / DD / YYYY*

**Primary Phone Number**

*Best phone number*

**Alternate Phone Number**

*Alternate number*

**Email Address**

*Patient email address*

**Patient's Preferred Method of Contact:**

☐ Phone Call ☐ Text Message ☐ Email ☐ No Preference

## EMERGENCY CONTACT

***Required for ALL patients receiving therapy for Alzheimer's Disease***

**Emergency Contact Name**

*Full name*

**Relationship to Patient**

*e.g. Spouse, Child, Friend*

**Emergency Contact Phone**

*Phone number*

**Emergency Contact Email**

*Email (if available)*

## PRIMARY INSURANCE: SUBSCRIBER INFORMATION

*Please confirm the subscriber / policy holder information for the patient's primary insurance.*

**Is the patient the Subscriber / Policy Holder?** ☐ Yes ☐ No

**Subscriber / Policy Holder Name**

*Full name*

**Relationship to Patient**

*e.g. Self, Spouse, Parent*

**Subscriber Date of Birth**

*MM / DD / YYYY*

**Subscriber Member ID**

*Member ID*

**Insurance Company**

*Insurance name*

**Group Number**

*Group number*

## COPAY ASSISTANCE PROGRAM

*If the patient is enrolled in a manufacturer copay or patient assistance program, please provide details if available.*

**Program Name**

*Program name*

**Program ID Number**

*ID number on card*

## NOTES / ADDITIONAL INFORMATION