☐ *Need a referral status update, Please provide your email:* _____

***Patient Insurance & ID (front and back) are needed**

DERMATOLOGY

☐ New Prescription/Referral
☐ Prescription Refill

 # Of Refills:

Rx: **Patient Name:** **Patient Weight:** kg **DOB:**

Spevigo (spesolimab-sbzo)
- ☐ 900mg IV *1
- ☐ Repeat 900mg IV in 1 week if symptoms persist
- ☐ Other: _____

IVIG
☐ Ok to use biosimilar
- ☐ Gamunex (10%) ☐ Privigen (10%) ☐ Octagam (10%) ☐ Gammaplex (10%)
- ☐ Gammagard (10%) ☐ Bivigam (10%) ☐ Gammaked(10%) ☐ Flebogamma DIF (10%)
- ☐ Asceniv (10%) ☐ Panzyga (10%) ☐ Other Orders:_____

Dosage: ☐ _____g/day IV ☐ _____g/kg IV ☐ Over_____# of days ☐ _____# of months

Frequency: ☐ One-Time Only ☐ every _____ weeks (Optional: Start Date _____)

Simponi Aria (golimumab)
- ☐ Initial Dose: 2mg/kg at weeks 0, 4, and then every 8 weeks
- ☐ Maintenance Dose: 2mg/kg every 8 weeks
- ☐ Other: _____

Infliximab
☐ Ok to use biosimilar
- ☐ Remicade ☐ Inflectra ☐ Renflexis ☐ Avsola

Dosage: _____ mg/kg IV

Frequency: ☐ 0, 2, 6, then every 8 weeks ☐ Every _____ weeks
☐ Other: _____

Rituximab
☐ Ok to use biosimilar

***Pre-Medication Required**
- ☐ Rituxan ☐ Ruxience ☐ Riabni ☐ Truxima

Dosage: ☐ 1000mg ☐ 500mg ☐ Other: _____
☐ 375mg/m2

Frequency: ☐ one time dose ☐ Weekly x 4 weeks ☐ Other:_____
☐ Repeat dose in 2 weeks ☐ Repeat after 6 months

☐ Other Orders: _____

Pre-Medication:
- ☐ Solumedrol 125mg IVP
- ☐ Solu-Cortef 100mg IVP
- ☐ Others: _____

☐ Tylenol _____ mg PO
☐ 650 mg ☐ 975 mg

☐ Benadryl _____ mg PO
☐ 25 mg ☐ IV
☐ 50 mg ☐ PO

ANA Kit Protocol
☐ OK to use

Dx: ICD-10: _____

Diagnosis: _____

Physician Signature **NPI #:** **DATE:(Valid for 1 year)**

By affixing my signature, I confirm the medical necessity of the aforementioned therapy, products, and services, as well as my responsibility for the patient's care. I have obtained consent to disclose the mentioned details and any relevant medical or patient information concerning this treatment. I grant the pharmacy permission to contact the insurance company on my behalf to secure authorization for the patient.

PHYSICIAN INFORMATION

Physician Name: **Clinic:**

Phone: **Fax:** **Email:** **Other:**

Office Mailing Address:

Please include the following
- ☐ *Patient demographics ☐ *Insurance attached ☐ *Diagnosis(supporting) ☐ *History & Physical
- ☐ *Lab Results ☐ *Clinical progress notes ☐ *Medication list ☐ *Other Test Results

- ☐ Hep B core antibody total(not IgM): (Required for: Rituximab)
- ☐ Hep B surface antigen: (Required for: Infliximab, Rituximab, Simponi Aria)
- ☐ TB Results within 12 months: (Required for: Infliximab, Simponi Aria, Spevigo)
- ☐ Baseline creatinine: (Required for: IVIG)
- ☐ Serum immunoglobulins: (Rituximab)

***If TB or Hep B results are positive - please provide documentation of treatment or medical clearance & a negative CXR (TB+)**

We can do patient teaching for IV/IM/SQ injections if needed. One time or multiple visits. If insurance allows we can also administer SQ/IM shot.