*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.