DERMATOLOGY

FAX: 725.228.5220

☐ New Prescription/Referral
☐ Prescription Refill

eMediate INFUSION

 # Of Refills:

PATIENT INFORMATION

*Please attach the copy of patient insurance & ID (front and back)

Name:	DOB:	Weight: kg

PHYSICIAN INFORMATION

Prescriber Name:	Phone:	Fax:
Office Contact:	*Email (for the referral update):	
Clinic:	Address:	
NPI:		
Patient's PCP Name:	Phone:	Fax:
Clinic:	Address:	
NPI:		

PRESCRIPTION INFORMATION (or attach a copy of the prescription)

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 ☐ _____g/kg ☐ 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:

Diagnosis:

ICD-10:

PRESCRIBER SIGNATURE: Date (Valid for 1 year):

I authorize eMediate Infusion Center, PLLC , Assist Point Clinical or its authorized representatives to initiate any insurance prior authorization process that is required for this prescription and for any future refills of the same prescription for the patient listed above which I order. I understand that I can revoke this designation at any time by providing written notice to eMediate Infusion Center.

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PATIENT INFORMATION

Name: DOB:

REQUIRED INFORMATION (please attach)

- ☐ **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)
- ☐ Serum immunoglobulins: (Rituximab)
- ☐ Baseline creatinine: (Required for: IVIG)
- ☐ TB Results within 12 months: (Required for: Infliximab, Simponi Aria, Spevigo)

***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