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○ New/Changed Dose

IV - Dermatology, Gastroenterology, Rheumatology (R-Z)

Remicade®, Rituxan®, Simponi Aria®, Skyrizi®, Stelara®

Prescriber Information

Prescriber Name:	○ MD ○ DO ○ NP ○ PA	NPI:	
Office Contact:	Practice Name / Collaborating MD:		
Address:	City:	State:	Zip:
Phone:	Fax:		

Patient Information • PLEASE SEND COPY OF INSURANCE CARD

Patients Name:	Last 4 Digits of SS#:	DOB: / /	Sex: ○ M ○ F	Weight:	Height:	Diabetic? ○ Y ○ N	
Address:	City:	State:	Zip:				
Home Phone:	Work/Cell:	HIPAA Contact:	Emergency #:				
Interpreter Needed? ○ Y ○ N	Allergies: ○ Y ○ N **If Yes, list allergies:**						

Insurance Information

Primary Insurance:	Policy ID:	Group #:	BIN:	PCN:
Policyholder Name:	Policyholder DOB: / /			

Dermatology • PLEASE SEND COPY OF MEDICAL AND PRESCRIPTION INSURANCE CARDS, PROGRESS NOTES AND LAB REPORTS, SUPPORTING DIAGNOSIS, CO-MORBIDITIES AND LAB VALUES

ICD-10/Diagnosis Code: ○ Psoriasis Vulgaris (L40.0) ○ Other Psoriasis (L40.8) ○ Psoriasis unspecified (L40.9) ○ Psoriatic Arthritis (L40.5) ○ Hidradenitis Suppurativa (L73.2) ○ Chronic Urticaria (L50.8)					
○ Atopic Dermatitis (L20.9) ○ Basal cell carcinoma (C44._____)	TB/PDD Test Given: ○ Y ○ N	Date of Neg. Test: / /	HBV Positive? ○ Y ○ N **If Yes, is patent currently treated?** ○ Y ○ N		
Prior Treatment? ○ Y ○ N **(Provide Information Below)**	BSA Affected (%):	Affected Areas: ○ Palms ○ Soles ○ Head ○ Neck ○ Genitalia ○ Other:			

Gastroenterology • PLEASE SEND COPY OF MEDICAL AND PRESCRIPTION INSURANCE CARDS, PROGRESS NOTES AND LAB REPORTS, SUPPORTING DIAGNOSIS, CO-MORBIDITIES AND LAB VALUES

ICD-10/Diagnosis Code: **Crohn's Disease:** ○ K50.0___(Crohn's of the **Small** Intestine) ○ K50.1___(Crohn's of the Large Intestine) ○ K50.8___(Crohn's of Both Intestines) ○ K50.9___(Crohn's, Unspecified)			
Ulcerative Colitis: ○ K51.0___(Ulcerative Pancolitis) ○ K51.2___(Ulcerative Procolitis) ○ K51.3___(Ulcerative Rectosigmoiditis) ○ K51.5___(Left Sided Colitis) ○ K51.8___(Other Ulcerative Colitis)			
○ K51.9___ (Ulcerative Colitis, Unspecified) ○ K58.0___ (Irritable Bowel Syndrome with Diarrhea) ○ Other:			
Date of Diagnosis: / /	Date of Negative TB Test: / /	Prior Treatment? ○ Y ○ N **(Provide Information Below)**	

Rheumatology • PLEASE SEND COPY OF MEDICAL AND PRESCRIPTION INSURANCE CARDS, PROGRESS NOTES AND LAB REPORTS, SUPPORTING DIAGNOSIS, CO-MORBIDITIES AND LAB VALUES

Diagnosis: ○ M32.9 Active Systemic Lupus Erythematosus ○ M45.9 Ankylosing Spondylitis ○ M08.0 Juvenile Idiopathic Arthritis ○ L40.59 Psoriatic Arthritis ○ L40.54 Psoriatic Juvenile Arthritis			
○ M06.9 Rheumatoid Arthritis ○ M45.A _____ Non-Radiographic Axial Spondyloarthritis ○ Other:			
Date Diagnosis: / /	Date of Neg. TB Test: / /	Any prior treatment? ○ Y ○ N **If Yes, provide information below:**	

Prior Therapy

Prior Therapy:	Reason for Discontinuation of Therapy:	Approx. Start Date: / /	
		Approx. End Date: / /	
Comorbidities:	Concomitant Medications:	Allergies: ○ NKDA ○ Other:	

Prescription Information

Medication	Quantity/Dose	Sig	Refills
○ **REMICADE®**	○ Number of 100mg vials: _____	○ **Starter Dose:** Infuse _____mg IV over 2 hours at weeks 0, 2 and 6	**No Refills**
		○ **Maintenance Dose:** Infuse _____mg IV over 2 hours once every _____ weeks	
○ **RITUXAN®**	○ Number of 100mg/10ml vials: _____ ○ Number of 500mg/50ml vials: _____	○ **Starter Dose:** Infuse 1000mg IV over 4-6 hours on day 1 and day 15	**No Refills**
		○ **Maintenance Dose:** Infuse 1000mg IV over 4-6 hours every _____ weeks	
○ **SIMPONI ARIA®**	○ Number of 50mg/4ml vials: _____	○ **Starter Dose:** Infuse _____ mg IV over 30 minutes at weeks 0 and 4	**No Refills**
		○ **Maintenance Dose:** Infuse _____ mg IV over 30 minutes once every 8 weeks	
○ **SKYRIZI®**	○ 1 Vial (600mg/10ml)	○ **Starter Dose:** Infuse 600mg IV over at least 1 hour at week 0, week 4 and week 8. Begin SQ maintenance regimen at week 12	**2 Refills**
○ **STELARA®**	○ Number of 45mg/0.5ml vials: _____ ○ Number of 130mg/26ml vials: _____	**Starter Dose:** Begin the SQ maintenance regimen 8 weeks after the initial IV dose ○ Weight > 85kg: Infuse 520mg IV over 1 hour ○ Weight 56kg – 85kg: Infuse 390mg IV over 1 hour ○ Weight ≤ 55kg: Infuse 260mg IV over 1 hour	**No Refills**

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Prescriber Signature	Date	Prescriber Signature	Date
Substitution Permitted		Dispense as Written	

If brand is required, please write "DAW" in the box to the right.