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○ New/Changed Dose

IV - Dermatology, Gastroenterology, Rheumatology (A-O)

Actemra®, Benlysta®, Cosentyx®, Entyvio®, Omvoh™, Orencia®

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)	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) ○ 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 of 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

	Quantity/Dose	Sig	Refills
○ **ACTEMRA®**	○ Number of 80mg/4ml vials: _____ ○ Number of 200mg/10ml vials: _____ ○ Number of 400mg/20ml vials: _____	○ Infuse _____ mg IV over 60 minutes every 4 weeks ○ Infuse _____ mg IV over 60 minutes every 2 weeks	
○ **BENLYSTA®**	○ Number of 120mg/5ml vials: _____ ○ Number of 400mg/20ml vials: _____	○ **Starter Dose:** Infuse _____mg IV over 1 hour at weeks 0, 2, and 4	**No Refills**
		○ **Maintenance Dose:** Infuse _____mg IV over 1 hour once every 4 weeks	
○ **COSENTYX®**	○ Number of 125mg/5ml vials: _____	**Starter Dose:** ○ Infuse _____mg at week 0 ○ No starter dose	**No Refills**
	○ Number of 125mg/5ml vials: _____	○ **Maintenance Dose:** Infuse _____mg every 4 weeks	
○ **ENTYVIO®**	○ **Starter Dose:** 2 vials	○ **Starter Dose:** Infuse 300mg IV over 30 minutes at weeks 0 and 2	**No Refills**
	○ **Maintenance Dose:** Number of 300mg vials:	○ **Maintenance Dose:** Infuse 300mg IV over 30 minutes once every 8 weeks beginning at week 6	
○ **OMVOH™**	○ Number of 300mg/15ml vials: _____	○ **Starter Dose:** Infuse 300mg at weeks 0, 4 and 8. Begin SQ maintenance dosing at week 12.	**No Refills**
○ **ORENCIA®**	○ Number of 250mg vials: _____	○ **Starter Dose:** Infuse _____ mg IV in 100ml NS over 30 minutes at weeks 0 and 2	**No Refills**
		○ **Maintenance Dose:** Infuse _____mg IV in 100ml NS over 30 minutes at week 4 and every 4 weeks thereafter	

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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.