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IV - Dermatology, Gastroenterology, Rheumatology

Benlysta®, Entyvio®, Krystexxa®, Orencia®, 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: | HIPPA 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
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	
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	
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	
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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Substitution Permitted		Dispense as Written	

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