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IV - Dermatology, Gastroenterology, Rheumatology

Benlysta®, Entyvio®, Krystexxa®, Orencia®, Remicade®, Rituxan®, Simponi Aria®, Stelara®

Physician Information

Send updates to: ◯ Fax: _____ ◯ Email: _____

Prescriber Name:		◯MD ◯DO ◯NP ◯PA	NPI:
Office Contact:	Practice name/Supervising MD:		
Address:	City:		
State:	Zip:	Phone:	Fax:

Patient Information | PLEASE SEND COPY OF INSURANCE CARD

Patient's Name:	Last 4 Digits of SS#:	DOB: / /	Sex: ◯ M ◯ F	Weight:	Height:	Diabetic: ◯ Y ◯ N
Address:	City:	State:	Zip:	Allergies:		
Home Phone:	Work Or Cell:	HIPAA Contact:	Emergency #:	Interpreter Needed? ◯ Y ◯ N		

Insurance Information

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

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, patient currently treated? ◯ Y ◯ N
Prior Treatment? ◯ Y ◯ N (Provide Information Below)	BSA affected (%):	Affected Areas: ◯ Palms ◯ Soles ◯ Head ◯ Neck ◯ Genitalia ◯ Other:		
Prior Therapy	Reason for Discontinuation of Therapy	Approximate Start Date	Approximate End Date	
Comorbidities:	Concomitant Medications:	Allergies: ◯ NKDA ◯ 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: / /	Any prior treatment? ◯ Yes ◯ No (provide information below)		
Prior Therapy	Reason for Discontinuation of Therapy			

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 Juvenille Arthritis	◯ M06.9 Rheumatoid Arthritis	◯ H20 Iridocyclitis (Uveitis)	◯ Other:	
Date of Diagnosis: / /	Date of Negative TB Test: / /	Any prior treatment? ◯ Yes ◯ No (provide information below)	Allergies: ◯ NKDA ◯ Other:	
Prior Therapy	Reason for Discontinuation of Therapy	Approx. Start Date	Approx. End Date	
Comorbidities:	Concomitant Medications:			

Prescription Information

TREATMENT ARRANGEMENTS: Ship Meds: ◯ Home ◯ Doctor's Office Start Date: / /

Medication	Dose/Strength	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®**	◯ Number of 300mg vials: _____	◯ **Starter dose:** Infuse 300mg IV over 30 minutes at weeks 0 and 2	No Refills
		◯ **Maintenance dose:** Infuse 300mg IV over 30 minutes once every 8 weeks beginning at week 6	
◯ **KRYSTEXXA®**	◯ Number of 8mg/ml vials: _____	◯ Infuse 8mg IV over 2 hours every 2 weeks	
◯ **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	
◯ **STELARA®**	◯ Number of 45mg/0.5ml vials: _____ ◯ Number of 90mg/ml vials: _____ ◯ Number of 130mg/26ml vials: _____	**Starter 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 Begin the SQ maintenance regimen 8 weeks after the initial IV dose	No Refills