Dermatology Referral Form

Please fax completed referral form to ivira:
(302) 486-3400
Please contact office for questions:
(302) 356-0506

PATIENT DEMOGRAPHICS:

PATIENT NAME:	PREFERRED CONTACT #:
DATE OF REFERRAL:	SECONDARY CONTACT #:
SOCIAL SECURITY NUMBER:	ADDRESS:
DATE OF BIRTH:	CITY, STATE, ZIP:

PRIMARY DIAGNOSIS: PLEASE PROVIDE ICD-IO CODE:

- ☐ L20.____ - Atopic Dermatitis
- ☐ L40.0 - Psoriasis vulgaris
- ☐ L40.1 - Generalized pustular psoriasis
- ☐ L40.2 Acrodermatitis continua
- ☐ L40.3 - Pustulosis palmaris et plantaris
- ☐ L40.4 - Guttate psoriasis
- ☐ L40.8 - Other psoriasis
- ☐ L40.9 - Psoriasis, unspecified
- ☐ L73.2 - Hidradentis suppurativa
- ☐ Other:______ - ______________________

PRIOR THERAPY: PLEASE PROVIDE MEDICATION HISTORY

PRIOR THERAPY (if any):

- ☐ TOPICALS: ____________________________
- ☐ PUVA
- ☐ UVB
- ☐ METHOTREXATE
- ☐ CYCLOSPORINE
- ☐ ORAL RETINOIDS
- ☐ ____________________________

APPROX START DATE: ________________

APPROX END DATE: ________________

REASON FOR DISCONTINUATION:

____
____
____
____

PATIENT INFORMATION:

ALLERGIES: ☐ NKDA	FIRST DOSE: ☐ Y ☐ N
	DATE OF LAST INFUSION:
	NEXT DOSE DUE BY:
HEIGHT: ____ Ft ____ In WEIGHT: ____ Lb or ____ Kg	ACCESS/LINE TYPE: ☐ PIV ☐ PORT ☐ PICC ☐ MIDLINE
GENDER: ☐ F ☐ M	OTHER:

REQUIRED DOCUMENTATION: Please provide a copy of the following documents.

☐ 1. INSURANCE CARD (Front & Back) ☐ 2. PATIENT DEMOGRAPHICS ☐ 3. MOST RECENT LABS ☐ 4. H & P ☐ 5. LABS

MEDICATION WASTE: FOR REMICADE

Authorized to round up to nearest vial size?
☐ YES ☐ NO

TESTING RESULTS: If prescribing: Cimzia, Humira, Remicade, Skyrizi, Stelara

TB SCREENING DATE: ________________

HEPATITIS-B PANEL DATE: ________________

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

☐ ADMINISTER ACUTE INFUSION AND ANAPHYLAXIS MEDICATIONS PER GREENHILL INFUSION POLICY AND PROCEDURE (See Reverse Side)

☐ OTHER: (please fax other reaction orders if checking this box)

PRN & PREMEDICATIONS:

MEDICATIONS	30 minutes prior every infusion	PRN
Acetaminophen ____ mg PO	☐	☐ PRN every ____ hours for mild or moderate infusion reaction.
Diphenhydramine ____ mg PO	☐	☐ PRN every ____ hours for mild or moderate infusion reaction.
Diphenhydramine ____ mg diluted in 10mL 0.9% NaCl slow IV push over 2-3 minutes.	☐	☐ PRN every ____ hours for mild or moderate infusion reaction.
Methylprednisolone ____ mg IV push over 5 minutes.	☐	
Methylprednisolone 100mg IV	☐	

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MEDICATION SELECTION:

Medication	Dosing
cimzia (certolizumab pegol)	**INDUCTION DOSE:** ☐ 400 MG SC WEEKS 0, 2, & 4 **MAINTENANCE DOSE:** ☐ 400 MG SC EVERY 2 WEEKS REFILLS:______
Cosentyx (secukinumab)	**INDUCTION DOSE:** ☐ 150 MG SC WEEKS 0, 1, 2, 3, & 4 *or* ☐ 300 MG SC WEEKS 0, 1, 2, 3, & 4 **MAINTENANCE DOSE:** ☐ 300 MG SC EVERY 4 WEEKS REFILLS:______
DUPIXENT (dupilumab)	**INDUCTION DOSE:** ☐ 400 MG SC *or* ☐ 600 MG SC **MAINTENANCE DOSE:** ☐ 200 MG SC EVERY OTHER WEEK *or* ☐ 300 MG SC QOW REFILLS:______
HUMIRA adalimumab	**INDUCTION DOSE:** ☐ 160 MG SC THEN 80 MG SC ON DAY 15, THEN 40 MG ON DAY 29 ☐ 80 MG SC THEN 40 MG SC ON DAY 8, THEN 40 MG EVERY 2 WEEKS **MAINTENANCE DOSE:** ☐ 40 MG SC EVERY TWO WEEKS ☐ 40 MG SC EVERY WEEK REFILLS:______
ILUMYA™ tildrakizumab-asmn	**INDUCTION DOSE:** ☐ 100 MG SC WEEKS 0 & 4 **MAINTENANCE DOSE:** ☐ 100 MG SC EVERY 12 WEEKS REFILLS:______
Remicade® INFLIXIMAB	**INDUCTION DOSE:** ☐ 5 MG/KG IV WEEKS 0, 2, & 6 **MAINTENANCE DOSE:** ☐ 5 MG/KG *or* ☐ 10 MG/KG IV EVERY 8 WEEKS **ALTERNATIVE:** ______ MG/KG IV EVERY _____ WEEKS REFILLS:______
Skyrizi™ risankizumab-rzaa	**INDUCTION DOSE:** ☐ 150 MG SC WEEKS 0 & 4 **MAINTENANCE DOSE:** ☐ 150 MG SC EVERY 12 WEEKS REFILLS:______
Stelara® (ustekinumab)	**INDUCTION DOSE:** ☐ 45 MG SC THEN 45 MG SC 4 WEEKS LATER ☐ 90 MG SC THEN 90 MG SC 4 WEEKS LATER **MAINTENANCE DOSE:** ☐ 45 MG SC EVERY 12 WEEKS AFTER LOADING DOSE ☐ 90 MG SC EVERY 90 WEEKS AFTER LOADING DOSE REFILLS:______
taltz® (ixekizumab) injection	**INDUCTION DOSE:** ☐ 160 MG AT WEEKS 0, FOLLOWED BY 80 MG AT WEEKS 2, 4, 6, 8, 10, & 12 **MAINTENANCE DOSE:** ☐ 80 MG SC EVERY 4 WEEKS REFILLS:______
Tremfya® (guselkumab)	**INDUCTION DOSE:** ☐ 100 MG SC AT WEEKS 0 & 4 **MAINTENANCE DOSE:** ☐ 100 MG SC EVERY 8 WEEKS REFILLS:______

PRESCRIBER INFORMATION:

PHYSICIAN NAME:	PHONE:
OFFICE CONTACT:	FAX:
ADDRESS:	LICENSE #:
CITY, STATE, ZIP:	NPI:

PHYSICIAN SIGNATURE: DATE: