Dermatology Referral Form

Please fax completed referral form to ivira:
(302) 499-8729

Please contact office for questions:
(302) 499-8727

PATIENT DEMOGRAPHICS:

PATIENT NAME: ______________________
DATE OF REFERRAL: ______________________
SOCIAL SECURITY NUMBER: ______________________
DATE OF BIRTH: ______________________

PREFERRED CONTACT #: ______________________
SECONDARY CONTACT #: ______________________
ADDRESS: ______________________
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 ______________________

HEIGHT:____ Ft ____ In WEIGHT:____Lb or ____ Kg

GENDER: ☐ F ☐ M

I hereby authorize Ivira to contact my prescribing provider to coordinate the delivery, receipt and storage of my prescription medication for the sole purpose of administration by my prescribing provider at my next scheduled appointment. Signature serves as the Patient Ship Authorization.

▶▶▶▶▶▶▶▶▶ ______________________
PATIENT SIGNATURE:

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	Refills
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:

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PHYSICIAN SIGNATURE: DATE: