AYSA
THERAPEUTICS INFUSION CENTER

DERMATOLOGY ORDER FORM

P: 470.395.6076 | F: 470.745.0716

PATIENT INFORMATION ☐ *Demographics attached*

Patient Name: _____ DOB: _____ Phone: _____

INSURANCE INFORMATION: PLEASE ATTACH COPY OF PRESCRIPTION/MEDICAL CARD(S) (FRONT AND BACK)

MEDICAL INFORMATION

Patient Weight: _____ lbs. Allergies: _____

Diagnosis Date: _____ ICD-10: _____ **Date of last: ☐ Orencia ☐ Remicade ☐ Humira ☐ Enbrel ☐ _____ ☐ Dose: _____

☐ Clinical/Progress Notes, Labs, Tests supporting primary diagnosis attached

Labs: Required labs to be drawn by: ☐ Infusion Clinic ☐ Referring Physician

Lab Orders: _____

Hepatitis B Protocol: Hep B surface antigen and Hep B Core AB total required (Cimzia, Remicade, Rituxan, and Simponi Aria)

Hep B Labs: ☐ Hep B antigen attached ☐ Hep B Core antibody total attached ☐ Draw Hep B Labs

TB Protocol: Baseline testing: Quantiferon Gold (QFT Gold) or PPD (Cimzia, Remicade, Stelara, and Ilumya)

TB Test: ☐ TB Test Attached ☐ Perform TB Testing

INJECTION AND INFUSION ORDERS

DIAGNOSIS	INFUSION ORDERS	REFILLS
☐ Cellulitis ☐ MRSA ☐ Skin Infection/Abscess	☐ Cubicin ☐ 4mg/kg IV ☐ 6mg/kg IV ☐ Baseline CPK and BMP ☐ Daily for _____ days _____ weeks ☐ Dalvance ☐ 1000mg IV followed one week later by 500mg ☐ 750mg IV followed one week later by 375mg (CrCl<30) ☐ 1500mg IV x 1 dose ☐ 1125mg IV x 1 dose (CrCl<30) ☐ Orbactiv 1200mg IV ☐ Rocephin ☐ 1gm IV ☐ 2gm IV ☐ Daily for _____ days _____ weeks	
☐ Dermatomyositis ☐ Dermatopolymyositis ☐ Phemphigoid/ Pemphigus ☐ Other: _____	☐ IVIG Orders: _____ gm/kg IV divided over _____ day(s) _____ mg/kg IV divided over _____ day(s) Frequency: Every _____ weeks for one year OR _____ one time dose Protocol Pre-Medication Orders: ☐ Tylenol 1000mg PO Antihistamine: ☐ Cetirizine 10mg PO ☐ Diphenhydramine 25mg PO ☐ Loratadine 10mg PO Additional Pre-Medication Orders: ☐ Solu-Medrol _____ mg IV ☐ NS 0.9%. _____ mL IV	
☐ Chronic Idiopathic Urticaria	☐ Xolair ☐ 150mg SQ every 4 weeks ☐ 300mg SQ every 4 weeks **Date of last injection: _____ Note: Patient must have an EpiPen in their possession on their appointment date	
☐ Pemphigus Vulgaris	☐ Rituxan Initial Dose: ☐ 1000mg IV at 0, 15 days Maintenance: ☐ 500mg IV at month 12 and every 6 months thereafter Pre-Medication Orders: Solu-Medrol 100mg IV, Tylenol 1000mg PO, and Benadryl 50mg PO/IV ☐ Other: _____ ☐ Prednisone Rx from referring provider	
☐ Psoriatic Arthritis ☐ Psoriasis ☐ Plaque Psoriasis	☐ Remicade _____ mg/kg IV every _____ weeks ☐ Remicade _____ mg/kg IV on weeks, 0, 2, 6 and then every 8 weeks Pre-Medication Orders: ☐ Tylenol 1000mg Antihistamine: ☐ Cetirizine 10mg PO ☐ Diphenhydramine 25mg PO ☐ Loratadine 10mg PO Additional Pre-Medication Orders: ☐ Solu-Medrol 62.5mg IV ☐ Solu-Medrol 125mg IV ☐ Solu-Cortef _____ mg IV ☐ SimponiARIA Initial Dose: ☐ 2mg/kg IV at weeks 0, 4 and then every 8 weeks Maintenance: ☐ 2mg/kg IV every 8 weeks ☐ Solu-Medrol 1gm IV daily x ☐ 3 days ☐ _____ days ☐ Stelara ☐ Patient weighing <100kg (220lbs.), 45mg SQ initially and 4 weeks later followed by 45mg every 12 weeks ☐ Patients weighing >100kg (220lbs.), 90mg SQ initially and 4 weeks later followed by 90mg every 12 weeks ☐ Ilumya Initial Dosing: ☐ 100mg SQ at weeks 0, 4 and every 12 weeks thereafter Maintenance: ☐ 100mg SQ every 12 weeks ☐ Cimzia ☐ 400mg subcutaneously every 4 weeks ☐ 200mg every 2 weeks ☐ 400 mg subcutaneously at weeks 0, 2, and 4 followed by 200mg every 2 weeks	

PHYSICIAN INFORMATION

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Physician Signature: _____ Physician Name: _ Date: _____ Phone: _____

Fax: _____ Contact Person: _____

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