

Dermatology Enrollment Form

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Phone: _____
 Patient Weight: _____ lbs. (required) Address: _____
 Patient Status: ☐ New to Therapy ☐ Continuing Therapy ☐ Next Treatment Date: _____

DIAGNOSIS

☐ CIU ☐ Generalized Pustular Psoriasis ☐ Psoriatic Arthritis
☐ Dermatomyositis ☐ Pemphigus Vulgaris ☐ Psoriasis
☐ Pemphigoid/ Pemphigus ☐ Plaque Psoriasis
☐ Other: _____
 ICD-10 Code: _____

THERAPY ORDER

MEDICATION	ORDERS	REFILL	PRE-MEDICATIONS	LAB ORDERS
☐ Cimzia	☐ 400mg SubQ at weeks 0, 2, and 4 followed by ☐ 200mg ☐ 400mg SubQ every 2 weeks ☐ 200mg SubQ every 2 weeks ☐ 400mg SubQ every 4 weeks		☐ Acetaminophen ☐ 500mg PO Please choose one antihistamine: ☐ Diphenhydramine ☐ 25mg PO ☐ 50mg PO ☐ Loratadine 10mg PO ☐ Cetirizine 10mg PO Additional Pre-medications: ☐ Solu-Medrol _____mg IVP ☐ Other: _____	☐ TB Screening Test* ☐ Cimzia ☐ Infliximab ☐ Ilumya ☐ Simponi Aria ☐ Positive ☐ Negative ☐ Hep. B Screening Test* (Hep. B surface antigen) ☐ Cimzia ☐ Infliximab ☐ Simponi Aria ☐ Positive ☐ Negative ☐ Hep. B Core Antibody Total (not IgM)* ☐ Rituximab ☐ Positive ☐ Negative ☐ Serum Immunoglobulins attach results ☐ Rituximab ☐ Baseline Creatinine ☐ IVIg *If TB or Hepatitis B results are positive - please provide documentation of treatment or medical clearance, and a negative CXR (TB+)
☐ Ilumya	Initial Dose: ☐ 100mg SubQ at weeks 0, 4, and every 12 weeks thereafter Maintenance: ☐ 100mg SubQ every 12 weeks			
☐ Infliximab or Infliximab Biosimilar	As required by patient's insurance ☐ Do not substitute. Infuse the following infliximab product: _____ ☐ For Internal Use Only. Brand: _____ Dose: _____mg/kg Frequency: ☐ Every _____ weeks OR ☐ 0, 2, 6 then every 8 weeks			
☐ IVIg	Orders: _____ mg/kg OR _____ gm/kg IV divided over _____ day(s) Frequency: Every _____ weeks x1 year OR _____ one time dose only Preferred Brand*: _____ *If left blank, clinicians to determine medication	☐ _____ ☐ x1 year		
☐ Rituximab or Rituximab Biosimilar*	As required by patient's insurance ☐ Do not substitute. Infuse the following rituximab product: _____ ☐ For Internal Use Only. Brand: _____ Initial Dose: ☐ 1000mg IV at 0, 15 days Maintenance: ☐ 500mg IV at month 12 and every 6 months thereafter Other Dose: _____ *Premedication Protocol: ☐ Solu-Medrol 100mg IV ☐ Tylenol 1000mg PO ☐ Benadryl 50mg PO/IV			
☐ Simponi Aria	Initial Dose: ☐ 2mg/kg IV at weeks 0 and 4 Maintenance: ☐ 2mg/kg every 8 weeks			

PROVIDER INFORMATION

Provider Name: _____ Date: _____
 NPI: _____ Phone: _____ Fax: _____ Contact Person: _____

PRESCRIBER SIGNATURE

Prescriber's Signature: _____
 Date: _____