Dermatology Infusion

Referral Form

PLEASE ATTACH INSURANCE CARDS - FRONT AND BACK

Email: intake@infuseoneohio.com
Fax: (614) 929-3349
Phone: (614) 929-3349

INFUSE ONE OHIO

PATIENT INFORMATION

Last Name, First Name | **Date of Birth** | **Gender** ☐ M ☐ F

Address | **City, State, ZIP** | **Phone**

REFERRING PROVIDER INFORMATION

Referring Practice | **Practice Address / City / State / ZIP**

Prescriber Name | **NPI** | **Nurse / Key Contact** | **Phone**

Fax | **Email**

NURSING & LABORATORY ORDERS

NURSE ORDERS Assessment, teaching, lab draws, medication administration, and vascular-access insertion/management per physician orders.

FLUSH ORDERS NaCl 0.9% 5-10 mL pre/post infusion and PRN. Heparin: ☐ 10 units/mL ☐ 100 units/mL ☐ 3-5 mL PRN

Lab Orders | **Lab Date & Frequency**

PRESCRIPTION ORDERS

CHECK ALL THAT APPLY

ANAPHYLAXIS KIT
☐ Epinephrine 0.3 mg IM PRN ☐ Solu-Cortef 250-500 mg IV PRN ☐ Solu-Medrol 60-125 mg IV PRN
☐ Diphenhydramine _____ mg IV PRN ☐ NS hydration 500 mL over 30 min PRN ☐ Other _____

PRE-MEDS
☐ Acetaminophen _____ mg PO _____ min prior ☐ Solu-Medrol _____ mg IV _____ min prior
☐ Diphenhydramine _____ mg ☐ PO ☐ IV infusion _____ min prior ☐ Other _____

☑ Supply all administration and vascular-access supplies needed to complete the ordered therapy.

PRESCRIPTION INFORMATION

PRODUCT	DIRECTIONS	REFILLS
First dose? ☐ Yes ☐ No	If no, last dose: _____ Next dose due: _____	
☐ Ilumya	100 mg subcutaneous at weeks 0 and 4, then every 12 weeks.	
☐ Infliximab ☐ Avsola ☐ Inflectra ☐ Remicade ☐ Renflexis	**INDUCTION:** _____ mg/kg OR _____ mg IV over at least 2 hours at weeks 0, 2, and 6. **MAINTENANCE:** _____ mg/kg OR _____ mg IV every _____ weeks. Round Medicaid doses to nearest 100 mg. If Remicade is tolerated, adjust infusion time per package insert.	
☐ Simponi Aria	2 mg/kg IV over 30 minutes at weeks 0 and 4, then every 8 weeks.	
☐ Spevigo	900 mg IV over 90 minutes; may repeat 900 mg one week later if flare persists.	
☐ Stelara	**PLAQUE PSORIASIS - ADULT SC** ☐ <=100 kg: 45 mg initially and 4 weeks later, then every 12 weeks ☐ >100 kg: 90 mg initially and 4 weeks later, then every 12 weeks **PLAQUE PSORIASIS - PEDIATRIC AGE 6-17 SC** ☐ <60 kg: 0.75 mg/kg initially and 4 weeks later, then every 12 weeks ☐ 60-100 kg: 45 mg; >100 kg: 90 mg, initially and 4 weeks later, then every 12 weeks	
☐ Xolair	☐ 150 mg ☐ 300 mg subcutaneous every 4 weeks	
☐ IG	Refer to Immunoglobulin Form.	
☐ Other		

AUTHORIZATION & PRESCRIBER SIGNATURE

By signing and using these services, I authorize Infuse One Ohio as my designated agent for prior authorization and insurer communications.

Prescriber Signature - Dispense as Written | **Print Name** | **Date**

Prescriber Signature - Substitution Permitted | **Print Name** | **Date**

REQUIRED ATTACHMENTS

☐ Demographics and front/back of all medical and prescription insurance cards
☐ Current medication list and prior therapies tried/failed with dates
☐ HBV labs within 12 months, when applicable
☐ Recent office notes, H&P, labs, and pertinent procedure results
☐ TB labs within 12 months, when applicable
☐ Medical necessity letter for non-FDA dosing or indication