Fax: 614-929-7199 | Phone: 614-929-3349 | Email: intake@infuseoneohio.com

Dermatology Referral Form

☐ Dublin, OH
☐ Lancaster, OH

INFUSE ONE OHIO

Please Attach Copy of Insurance Cards (Front & Back)

Last Name, First Name: _____ Date of Birth: _____ Gender: ☐ M ☐ F ☐ Other

Address: _____

Phone: _____ City, State, Zip: _____

Referring Practice: _____

Practice Address: _____ City, State, Zip: _____

Prescriber Name: _____ Prescriber NPI: _____

Nurse/Key Contact: _____ Phone: _____

Fax: _____ Email: _____

Diagnosis & Clinical Information

ICD-10:_____ Description:_____

☑ Center will use Hypersensitivity protocol established by Infuse One Ohio

Prescription Orders

Anaphylaxis Kit: (Check all that apply)	☐ Epinephrine 0.3mg IM as needed ☐ Solu-cortef 250mg-500mg IV infusion as needed ☐ Solu-Medrol 60mg - 125mg IV infusion as needed ☐ Diphenhydramine _____ mg IV infusion as needed ☐ NS Hydration 500 ml IV infusion over 30 minutes as needed ☐ Other
Pre-Medications: (Check all that apply)	☐ Acetaminophen _____mg PO _____ minutes prior to infusion ☐ Solu-Medrol ____mg IV __minutes prior to infusion ☐ Diphenhydramine _____ mg ☐ PO ***---OR---*** ☐ IV infusion _____minutes prior to infusion ☐ Other
Supply Orders: All supplies for vascular access line care, drug administration kit(s), pump, and IV pole will be provided as necessary	

Prescription Information

PRODUCT	DIRECTIONS	REFILLS
Is this a first dose? ☐ Yes ☐ no if no, when was last dose given?_____ When is patient due for next dose?_____		
☐ Ilumya	100mg sc injection at 0 and 4 weeks then every 12 weeks	
☐ Infliximab ☐ Avsola ☐ Inflectra ☐ Remicade ☐ Renflexis	☐ **INDUCTION:** _____mg/kg or _____mg iv infusion via ☐ gravity ***---OR---*** ☐ pump over at least 2 hours at weeks 0, 2, and 6	NONE
	☐ **MAINTENANCE:** _____mg/kg _____ mg iv infusion via ☐ gravity ***---OR---*** ☐ pump over at least 2 hours every _____ weeks *(Note: round to nearest 100mg for medicaid patients)* If remicade infusion tolerated, adjust infusion time according to manufacturer package insert.	
☐ Simponi Aria	2 mg/kg IV infusion via ☐ gravity ***---OR---*** ☐ pump over 30 minutes at weeks 0 and 4, and every 8 weeks thereafter	
☐ Spevigo	☐ 900 Mg iv infusion over 90 minutes ☐ Additional 900 mg iv infusion over 90 minutes one week after initial dose if flare symptoms persist	
☐ Stelara	**Psoriasis Adult Subcutaneous** ☐ For patients <= 100 kg, 45 mg SC injection initially and 4 weeks later, followed by 45 mg every 12 weeks ☐ For patients > 100 kg, 90 mg SC injection initially and 4 weeks later, followed by 90 mg every 12 weeks	
	Psoriasis Pediatric Patients 6 to 17 (based on weight at time of initial dose) ☐ For patients <= 60 kg, 0.75 mg/kg SC injection initially and 4 weeks later, then every 12 weeks ☐ For patients 60 kg – 100kg, 45 mg SC injection initially and 4 weeks later, then every 12 weeks ☐ For patients >100kg, 90 mg SC injection initially and 4 weeks later, then every 12 weeks	
	Psoriasis Adult Subcutaneous ☐ 45 mg SC injection initially and 4 weeks later, followed by 45 mg SC injection every 12 weeks ☐ For patients with co-existent moderate-to-severe plaque psoriasis weighing >100 kg, 90 mg SC injection initially and 4 weeks later, then every 12 weeks	
☐ Xolair	☐ 150 or ☐ 300 mg SC injection once every 4 weeks	
☐ IG	***For Immunoglobulin therapy please refer to Immunoglobulin Form***	
☐ Other		

By signing this form and utilizing our services, you are authorizing Infuse One Ohio to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

DISPENSE AS WRITTEN
Prescriber's Signature: _____ Print Name: _____ Date: _____

SUBSTITUTION PERMITTED
Prescriber's Signature: _____ Print Name: _____ Date: _____

Please be sure to attach the following: Provider Phone Line: (614) 929-3349

- ☐ Patient demographics & front/back copy of all insurance cards (prescription & medical)
- ☐ Recent office visit notes, history & physical, lab & pertinent procedure results
- ☐ Current medication list & list of prior medications tried and failed (with dates)
- ☐ TB lab results within last 12 months *(Stelara, Simponi Aria, Ilumya & Infliximabs only)*
- ☐ HBV lab results within last 12 months *(Infliximabs & Simponi Aria only)*
- ☐ Letter of medical necessity if drug dosing or indication is outside of FDA guidelines