



## DERMATOLOGY THERAPY

Referral Fax: 256-415-6415

Phone: 256-415-6542

email: info@mkinfusion.com

**PATIENT INFORMATION:** Fax completed form, insurance information, and clinical documentation to 256-415-6415.

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_

Patient Status: New to Therapy Continuing Therapy Next Treatment Date: \_\_\_\_\_

### MEDICAL INFORMATION

Patient Weight: \_\_\_\_\_ lbs./kg. (required) Allergies: \_\_\_\_\_

### THERAPY ORDER

Diagnosis	Medication Orders	Refills
<input type="checkbox"/> Dermatomyositis <input type="checkbox"/> Polymyositis <input type="checkbox"/> Pemphigoid/Pemphigus ICD-10: _____	<b>IVIg Orders:</b> _____ mg/kg <b>OR</b> _____ gm/kg IV x _____ day(s) <b>OR</b> divided over _____ days(s) <b>Frequency:</b> Every _____ weeks <b>OR</b> _____ Preferred brand: _____ (Active Infusions to choose if not indicated) Additional Ig orders: _____	<input type="checkbox"/> x 1 year <input type="checkbox"/> _____
<input type="checkbox"/> Pemphigus Vulgaris ICD-10: _____	<input type="checkbox"/> <b>Remicade or rituximab biosimilar</b> (as required by patient's insurance) <input type="checkbox"/> Do not substitute. Infuse the following rituximab product: _____ Initial Dose: 1000mg IV at day 0, 15 days Maintenance Dose: 500mg IV at month 12 and every 6 months thereafter Other dose: _____ <b>Protocol Premedication Orders: Solu-Medrol 100mg IV, Tylenol 1000mg PO, and Benadryl 50mg PO/IV</b>	<input type="checkbox"/> X 1 year <input type="checkbox"/> _____
<input type="checkbox"/> Psoriatic Arthritis <input type="checkbox"/> Psoriasis <input type="checkbox"/> Plaque Psoriasis ICD-10: _____	<input type="checkbox"/> <b>Remicade/Infliximab/infliximab biosimilar</b> (as required by patient's insurance) <input type="checkbox"/> Do not substitute. Infuse the following infliximab product: _____ <b>Dose:</b> _____ mg/kg <b>Frequency:</b> Every _____ weeks <b>OR</b> 0, 2, 6, then every 8 weeks <b>Simponi Aria</b> Initial Dose: 2mg/kg IV at weeks 0, 4, and then every 8 weeks Maintenance Dose: 2mg/kg IV every 8 weeks <b>Stelara</b> 45mg SQ initially and 4 weeks later followed by 45mg SQ every 12 weeks (<100kg) 90mg SQ initially and 4 weeks later followed by 90mg SQ every 12 weeks (>100kg) Maintenance Dose: 45mg SQ every 12 weeks <b>OR</b> 90mg SQ every 12 weeks <b>Ilumya</b> Initial Dose: 100mg SQ at weeks 0, 4, and every 12 weeks thereafter Maintenance Dose: 100mg SQ every 12 weeks <b>Cimzia</b> 200mg SQ every 2 weeks <b>OR</b> 400mg SQ every 4 weeks <b>OR</b> 400mg SQ every 2 weeks 400mg SQ at weeks 0, 2, and 4 followed by: 200mg <b>OR</b> 400mg every 2 weeks	<input type="checkbox"/> x 1 year <input type="checkbox"/> _____

**Premedication orders:** Tylenol 1000mg OR 500 mg PO  
 Please choose one antihistamine: Diphenhydramine 25mg PO Loratadine 10mg PO Cetrizine 10mg PO Other: \_\_\_\_\_  
 Additional premedications: Solu-Medrol \_\_\_\_\_ mg IVP Solu-Cortef \_\_\_\_\_ mg IVP Other: \_\_\_\_\_

Please provide patient's demographic information, insurance information, medication list, and clinical notes. MKIC will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and assist them in enrolling in any available co-pay assistance programs as needed/applicable. Thank you for the referral.

### PROVIDER INFORMATION

Provider Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Provider NPI: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Contact Person: \_\_\_\_\_

IMPORTANT NOTICE: This fax is intended to be delivered only to the named address and contains material that is confidential, privileged property, or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately and destroy all copies if you have received this document in error.



DERMATOLOGY THERAPY

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PATIENT INFORMATION:

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING AND INSURANCE APPROVAL

- Include signed and completed order (MD/prescriber to complete previous page)
Include patient demographic information and insurance information
Include patient's medication list
Supporting clinical notes (H&P) to include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy
For biologic orders, has the patient had a documented contraindication/intolerance or failed trial of a conventional therapy (i.e., steroids)? Yes No
If yes, which drug(s)
For biologic orders, does the patient have a contraindication/intolerance or failed trial to any other biologic (i.e., Stelara, Cimzia)? Yes No
Include labs and/or test results to support diagnosis (attach)
If applicable - Last known biological therapy: and last date received:
If patient is switching biologic therapies, please perform a wash out period of weeks prior to starting ordered biologic therapy.
Other medical necessity:

REQUIRED PRE-SCREENING (BASED ON DRUG THERAPY)

- TB screening test completed within 12 months - attach results
Required for: Cimzia, Infliximab, Stelara, Ilumya, Simponi Aria, Spevigo
Positive Negative
Hepatitis B screening test completed (Hepatitis B surface antigen) - attach results
Required for: Cimzia, Infliximab, Simponi Aria
Positive Negative
Hepatitis B core antibody total (not IgM) - Positive Negative
Required for: Rituximab
Serum immunoglobulins - attach results Recommended for: Rituximab
Baseline creatinine Required for: IVIG

\*If TB or Hepatitis B results are positive, please provide documentation of treatment or medical clearance and a negative CXR (TB+)

Please fax all information to 256-415-6415 or email to info@mkinfusion.com for assistance