VEROS HEALTH
Excellence in Complex Care

Dermatology Referral Form

Please complete the following and fax with clinical documentation to:
720.279.7461

Referral Process

1. PATIENT INFORMATION

Name:

Address:

City: State: Zip:

Home Phone: Other Phone:

Email:

DOB: Social Security #:

Gender: ☐ M ☐ F Height: Weight:

2. PHYSICIAN INFORMATION

Physician's name:

License #: NPI #:

DEA #:

Address:

City: State: Zip:

Office Contact:

Phone: Fax:

3. DIAGNOSIS

☐ Plaque Psoriasis (L41.4)
☐ Psoriatic Arthritis (L40.50)
☐ Atopic Dermatitis (L20.9)
☐ Pemphigus Vulgaris (PV) (L10.0)
☐ Other:

TB Test ☐No ☐Yes | If yes, result:
☐Positive ☐Negative
Hepatitis Test ☐No ☐Yes | If yes, result:
☐Positive ☐Negative

% BSA Affected:

4. INSURANCE INFORMATION

Please submit copies of the front and back of primary and secondary insurance cards with this referral.

5. PRESCRIPTION INFORMATION (Medication, Dosage, Duration, Pre-Medication)

☐ **Avsola®**
☐ Loading dose: 5 mg/kg IV @ 0, 2 and 6 weeks ☐Infuse in NS 250ml over 2 hours as directed
☐ Maintenance: 5 mg/kg IV every 8 weeks. Refills x _____ Months.

☐ **Cimzia® 200 mg single dose vial or 200 mg/ml prefilled syringe**
☐ **Psoriatic Arthritis**
☐ Loading dose: Inject 400 mg SC initially and at weeks 2 and 4
☐ Maintenance: Inject 200 mg every 2 weeks. # of Refills _____
☐ Maintenance: Inject 400 mg every 4 weeks. # of Refills _____

☐ **Plaque Psoriasis**
☐ Inject 400 mg SC every other week. # of Refills _____
☐ For some patients (≤90kg) a dose of 400 mg initially and at weeks 2 and 4, followed by 200 mg every other week may be considered. # of Refills _____

☐ **Dupixent® 200 mg/1.14 ml prefilled syringe**
☐ Adolescents (less than 60 kg):
Initial dose of 400 mg (two 200 mg injections) subcutaneously followed by 200 mg every other week
OR
☐ Adults and adolescents (60 kg or more):

☐ **Dupixent® 300 mg/2 ml prefilled syringe**
Initial dose of 600 mg (two 300 mg injections) subcutaneously followed by 300 mg every other week

☐ **Enbrel®**
☐ 25 mg prefilled syringe ☐ 50 mg prefilled syringe ☐ 25 mg multi-use vial ☐ 50 mg Sureclick®
☐ Inject 50 mg SC once per week ☐ Inject 50 mg SC twice per week x three months, then 50 mg once per week
☐ Inject _____ mg SC _____ times per week. Refills x _____ Months.

☐ **Humira®**
☐ 40 mg/0.8ml prefilled syringe ☐40 mg/0.8ml Pens
☐ Loading dose: Inject 80 mg SC initial dose, followed by 40 mg every other week starting one week after initial dose
☐ Maintenance: Inject 40 mg SC every other week. Maintenance Dose. Refills x _____ Months.

Dermatology Referral Form, continued

☐ **Inflectra®**
- ☐ Loading dose: 5 mg/kg @ 0, 2 and 6 weeks ☐Infuse in NS 250ml over 2 hours as directed
- ☐ Maintenance: 5 mg/kg q 8 week Maintenance Dose. Refills x _____ Months.

☐ **Ilumya®100 mg/ml prefilled syringe**
- ☐ Loading dose: Inject 100 mg SC at weeks 0 and week 4
- ☐ Maintenance: Inject 100 mg SC every 12 weeks thereafter. # of Refills _____

☐ **Orencia® 250 mg single dose vial (for IV infusion)**
- ☐ Initial dose: Infuse _____ mg IV over 30 minutes in 100 mls 0.9% Sodium Chloride, at weeks 0, 2 and 4
- ☐ Maintenance dose: Infuse _____ mg IV over 30 minutes in 100 mls 0.9% Sodium Chloride every 4 weeks. # of Refills _____

☐ **Orencia® prefilled syringes 125 mg/ml (for SC injection)** Inject 125 mg/1 ml SC once weekly. # of Refills _____

☐ **Otezla®** 30 mg orally twice daily starting on day 6. Initial dosage titration from day 1 or day 5 as follows:
Day 1 - AM: 10 mg; Day 2 - AM: 10 mg and PM: 10 mg; Day 3 – AM: 10 mg and PM: 20 mg;
Day 4 - AM: 20 mg and PM: 20 mg; Day 5 – AM: 20 mg and PM: 30 mg. # of Refills _____

☐ **Remicade®**
- ☐ Loading dose: 5 mg/kg @ 0, 2 and 6 weeks ☐Infuse in NS 250ml over 2 hours as directed
- ☐ Maintenance: 5 mg/kg q 8 week Maintenance Dose. Refills x _____ Months.

☐ **Renflexis®**
- ☐ Loading dose: 5 mg/kg @ 0, 2 and 6 weeks ☐Infuse in NS 250ml over 2 hours as directed
- ☐ Maintenance: 5 mg/kg q 8 week Maintenance Dose. Refills x _____ Months.

☐ **Rituxan®**
- ☐ Administer Rituxan as two 1,000 mg intravenous infusions separated by 2 weeks in combination with a tapering course of glucocorticoids.

Maintenance treatment:
- ☐ Administer Rituxan as a 500 mg intravenous infusion at month 12 and every 6 months (time period between infusions may vary based on clinical evaluation*. Secure new physician order prior to each subsequent dose).

Treatment of relapse:
- ☐ Administer Rituxan as a 1,000 mg intravenous infusion on relapse*, and consider resuming or increasing the glucocorticoid dose based on clinical evaluation.
- ☐ Dilute to a final concentration of 1 mg/ml to 4 mg/ml in either 0.9% Sodium Chloride or 5% Dextrose Injection

*Subsequent infusions of Rituxan may be administered no sooner than 16 weeks following the previous infusion.

Pre-medicate with:
- ☐ Methylprednisolone 100 mg intravenous 30 minutes prior to each infusion
- ☐ Other Glucocorticoid: _____

☐ **Simponi® 50 mg / 0.5 ml single-dose prefilled syringe**
- ☐ Inject 50 mg SC once monthly. Refills x _____ Months.

☐ **Stelara®**
- ☐ **45 mg prefilled syringe**
  - ☐ Loading dose: Inject 45 mg SC at week 0 and week 4
  - ☐ Maintenance: Inject 45 mg SC every 12 weeks thereafter. Refills x _____ Months.
- ☐ **90 mg prefilled syringe**
  - ☐ Loading dose: Inject 90 mg SC at week 0 and week 4
  - ☐ Maintenance: Inject 90 mg SC every 12 weeks thereafter. Refills x _____ Months.
- ☐ **Nursing Orders:**
  - ☐ Administer Stelara by subcutaneous injection
  - ☐ Loading Dose: Week 0 Date to initiate therapy: _____
  - ☐ Loading Dose: Week 4
  - ☐ Maintenance Dose: Q12 weeks from date of last injection

Dermatology Referral Form, continued

☐ **Taltz® 80 mg/ml prefilled syringe**
- ☐ **Psoriatic Arthritis**.
- ☐ Initial dose: Inject 160 mg (two 80 mg injections) SC
- ☐ Maintenance dose: Inject 80 mg SC every 4 weeks. # of Refills _____
- ☐ **Plaque Psoriasis**:
- ☐ Initial dosing: Inject 160 mg (two 80 mg injections) SC followed by 80 mg at weeks 2, 4, 6, 8, 10, and 12
- ☐ Maintenance dose: Inject 80 mg SC every 4 weeks. # of Refills _____

☐ **Tremfya® 100 mg/ml prefilled syringe**
- ☐ Initial dose: Inject 100 mg SC at week 0 and 4.
- ☐ Maintenance dose: Inject 100 mg SC every 8 weeks. # of Refills _____

6. FLUSH ORDERS

PIV/midline/PICC: Flush before, after each infusion, and as needed with 3-20 ml NS, followed by Heparin 2-5 ml if indicated
☐ Heparin 10 unit/ml ☐ Heparin 100 unit/ml

Port: Flush before, after each infusion, and as needed with 5-20 ml NS, followed by:
☐ Heparin 100 unit/ml 5 ml for adults ☐ Heparin 10 unit/ml 5 ml for pediatrics

7. ANAPHYLAXIS ORDERS

Adults: For mild reaction-administer diphenhydramine 50mg IVP/PO x 1.
For severe reactions-administer epinephrine 0.3mg SubQ/IM x 1. May repeat x1 if needed. Contact 911 and monitor vital signs.
Pediatrics: administer by age: *For mild reaction (rash/hives) give diphenhydramine*
Age 1-5: 12.5mg IV/PO x1 **Age 6-11**: 25mg IV/PO x1 **Age 12+:** 50mg IV/PO x1
For severe reaction (airway closure) administer epinephrine. 0.01mg/kg/dose (max 0.3mg) SubQ/IM x 1.
If needed, repeat a second dose after 5-10 minutes for a maximum of two doses. Contact 911 and monitor vital signs.

☐ Other: _____

8. ☐ Dispense as written ☐ Substitution Permitted

PHYSICIAN'S SIGNATURE (required): _____ **Date:** _____

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Prescription is valid for one year unless otherwise indicated.
The prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.