CONTINUUMRX
Specialty Infusion Services

Birmingham, AL F: 205-271-9971
Huntsville, AL F: 256-417-6408
Knoxville, TN F: 865-934-0249
Nashville, TN F: 615-645-4791
Chantilly, VA F: 703-935-2061

Dermatology Medication

Date: _____ Patient Name: _____ Date of Birth: _____

PREVIOUS ADMINISTRATION

Please provide the following information: Last Infusion Date: _____ Next Infusion Date: _____

DIAGNOSIS

Description ◯ Plaque Psoriasis ◯ Psoriatic Arthritis | **ICD-10 Code** ◯ L40.9 ◯ L40.52

OTHER REQUIRED DOCUMENTATION (Please attach documents as needed)

◯ This signed order form ◯ History and Physical ◯ Patient Demographics and Insurance Information
◯ Clinical progress notes, lab work (including most recent renal function tests and any other tests supporting primary diagnosis)

CLINICAL INFORMATION (Please attach all clinical information, lab results and other medical history documents)

Patient weight: _____ Lbs Height: _____ Inches Allergies: _____
Line Access: ◯ PIV ◯ PICC (SL DL TL) ◯ PORT ◯ Sub-Q

MEDICATION	DOSE	DIRECTIONS	LAB & ANCILLARY ORDERS	REFILLS
◯ Cimzia	2x200mg Syr	◯ 400mg (2x200mg) SQ every 2 wks ◯ Pt <=90kg - consider 400mg SQ wks 0, 2 & 4 followed by 200mg every 2 wks		
◯ Cosentyx	◯ 2x150mg/mL Syr ◯ 1x150mg/mL Syr ◯ 1x75mg/0.5mL Syr	◯ 300mg SQ at wks 0, 1, 2, 3 & 4 then 300mg every 4 wks ◯ 300mg SQ at wks 0, 1, 2, 3 & 4 then 150mg every 4 wks ◯ 150mg SQ at wks 0, 1, 2, 3 & 4 then 150mg every 4 wks ◯ 75mg SQ at wks 0, 1, 2, 3 & 4 then 75mg every 4 wks		
◯ Humira	◯ 40mg/0.4mL Pen ◯ 80mg/0.9mL Pen	◯ 40mg SQ every other wk ◯ 80mg on day 1 then 40mg SQ every other wk starting 1 wk after initial dose		
◯ Ilumya	100mg/mL Syr	◯ 100mg SQ at wks 0, 4 then every 12 wks thereafter ◯ 100mg SQ at wks 0, 4 then 200mg every 12 wks thereafter		
◯ Orencia	250mg Vial	◯ Initiation: 1000mg, 750mg or 500mg IV over 30 min every 2 wks for 3 doses ◯ Maintenance: 1000mg, 750mg or 500mg IV over 30 min every 4 wks		
◯ Simponi	50mg/0.5mL Injector	50mg SQ once per month		
◯ Simponi Aria	50mg/4mL	2mg/kg/dose IV at wks 0, 4 then every 8 wks		
◯ Skyrizi	150mg/mL Syr	150mg SQ at wks 0, 4 then every 12 wks		
◯ Taltz	80mg/mL Syr or Prefilled Injector	◯ 160mg SQ at wk 0 (2x80mg injections) then 80mg SQ every 4 wks ◯ 160mg SQ at wk 0 (2x80mg injections) then 80mg SQ at wks 2, 4, 6, 8, 10, & 12 then 80mg SQ every 4 wks ◯ 160mg SQ at wk 0 (2x80mg injections) then 80mg SQ at wks 2, 4, 6, 8, 10, & 12 then 80mg SQ every 2 wks		
◯ Tremfya	100mg/mL Syr or Prefilled Injector	100mg SQ at wk 0, 4 then every 8 wks thereafter		
◯ Stelara	◯ 130mg/ 26mL vial ◯ 45mg/0.5mL vial ◯ 90mg/mL Injector	◯ Pt >100kg - 90mg SQ at wk 0, 4 then every 12 wks starting at wk 16 ◯ Pt <=100kg - 45mg SQ at wk 0, 4 then every 12 wks starting at wk 16		

Premedication(s)
◯ Diphenhydramine 25-50 mg po - 25mg #2 per dose
◯ Acetaminophen 325-650 mg po - 325mg #2 per dose
◯ Methylprednisolone _____ mg IV over _____ mins
◯ Other: _____

Ancillary orders will include:
NaCl 0.9% 5-10ml IV before and after infusion
Heparin 10 units/ml 3-5ml IV after infusion for peripheral access and PRN
Heparin 100 units/ml 3-5ml IV after infusion for central IV access and PRN
All infusion supplies necessary to administer the medication
Anaphylaxis Kit

By signing below, I certify that above therapy is medically necessary. Presriber's Signature (SIGN BELOW)

By signing this form and utilizing our services, I am also authorizing ContinuumRx to serve as my prior authorization agent with medical and pharmacy insurance providers.

Physician signature: _____ Date: _____

Physician name: (Please print) _____

Phone: _____ Fax: _____ License #: _____ NPI #: _____