Dermatology Therapies

Please fax completed referral form to 972-473-7563

PATIENT DEMOGRAPHIC INFORMATION

Patient's name: _____ Date of birth: _____ Phone #: _____

Address: _____ City/State/Zip: _____

Allergies: _____ Weight: _____ Height: _____

DIAGNOSIS & CLINICAL INFORMATION

Diagnosis: *(ICD 10 Code Required)*

☐ Plaque Psoriasis (L40.0-L40.9), ICD 10_____ ☐ Arthropathic Psoriasis (L40.50-L40.59), ICD 10_____

☐ Idiopathic Urticaria, L50.1 ☐ Other Urticaria, L50.8 ☐ Other: _____

Prior Failed Therapy:

Med Failed: _____ Length of Treatment: _____ Reason for D/C: _____

Med Failed: _____ Length of Treatment: _____ Reason for D/C: _____

Med Failed: _____ Length of Treatment: _____ Reason for D/C: _____

Test Results: Please attach copy for all items checked.

☐ Negative TB test

☐ Other: _____

Please include copy of insurance card, most recent H&P or MD note, medication list, and lab results.

THERAPY ORDERED

MEDICATION	DOSE	DIRECTIONS/DURATION
Xolair® (omalizumab)	☐ 150mg ☐ 300mg	☐ Inject SUBQ every 4 weeks x 1 year
Remicade® (infliximab)	☐ **5mg/kg:** _____mg ☐ **Other:** _____mg	☐ **INITIAL:** Infuse IV at Weeks 0, 2, and 6 ☐ **MAINTENANCE:** Infuse IV every 8 weeks x 1 year ☐ **MAINTENANCE:** Infuse IV every ____ weeks x 1 year
Renflexis® (infliximab-abda)	☐ **5mg/kg:** _____mg ☐ **Other:** _____mg	☐ **INITIAL:** Infuse IV at Weeks 0, 2, and 6 ☐ **MAINTENANCE:** Infuse IV every 8 weeks x 1 year ☐ **MAINTENANCE:** Infuse IV every ____ weeks x 1 year
Inflectra® (infliximab-dyyb)	☐ **5mg/kg:** _____mg ☐ **Other:** _____mg	☐ **INITIAL:** Infuse IV at Weeks 0, 2, and 6 ☐ **MAINTENANCE:** Infuse IV every 8 weeks x 1 year ☐ **MAINTENANCE:** Infuse IV every ____ weeks x 1 year
Simponi Aria™ (golimumab)	_____mg (2mg/kg)	☐ **LOADING:** Infuse IV at Weeks 0 and 4 ☐ **MAINTENANCE:** Infuse IV every 8 weeks x 1 year
Ilumya™ (tildrakizumab-asmn)	100mg	☐ **INITIAL:** Inject SUBQ at Weeks 0 and 4 ☐ **MAINTENANCE:** Inject SUBQ every 12 weeks x 1 year
Dupixent® (dupilumab)	**INITIAL:** 600mg **MAINTENANCE:** 300mg	☐ **INITIAL:** Inject 600mg SUBQ x 1 dose ☐ **MAINTENANCE:** Inject 300mg SUBQ every 2 weeks x 1 year
OTHER:		

Is patient currently receiving therapy above from another facility? ☐ **NO** ☐ **YES** If yes, Facility Name: _____

REFERRING PHYSICIAN INFORMATION

Physician Name: _____ Specialty: _____

Address: _____ City/State/Zip: _____

Office Contact: _____ Phone #: _____ Fax #: _____

AIR Care
Allergy, Immunology & Respiratory Care

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