INTEGRATED CARE SYSTEMS

# DERMATOLOGY
## IMMUNE GLOBULIN & BIOLOGICS
## PATIENT REFERRAL FORM

**PHONE 800.734.2896**
**FAX 559.734.6451**

| Patient Last Name First Name | Referral Date |
|---|---|
| ○ Male ○ Female DOB: | Prescriber |
| **Weight** _____ lbs **Height** _____ in | Provider Phone # Fax # |
| ○ **NKDA**<br>○ **Allergies** _____ | Nurse/Office Contact |

### PRIMARY DIAGNOSIS

- ○ Dermatomyositis, unspecified with respiratory involvement ***M33.91***
- ○ Dermatomyositis, unspecified with organ involvement ***M33.92***
- ○ Pemphigus Vulgaris ***L10.0***
- ○ Pemphigus Vegetans ***L10.1***
- ○ Pemphigus Foliaceous ***L10.2***
- ○ Brazilian Pemphigus ***L10.3***
- ○ Pemphigus Erythematosus ***L10.4***
- ○ Hidradenitis Suppurativa ***L73.2***
- ○ Other _____

### PHYSICIAN ORDER BIOLOGICS

○ **REMICADE (Infliximab)**

**DOSE**

○ 3mg/kg ○ 5mg/kg ○ 7.5mg/kg ○ 10mg/kg

○ Round up to the nearest 100mg

**FREQUENCY**

○ Induction: Week 0,2,6, and then every 8 weeks

○ Maintenance: Every 8 weeks

○ **STELARA (ustekinumab)**

**PLAQUE PSORIASIS DOSE**

○ 45mg ○ 90mg

**FREQUENCY**

○ Induction: Week 0,4,6, and then every 12

## PLEASE FAX THE FOLLOWING ALONG WITH THIS ORDER

**-Face sheet/Demographics**
**-H&P**
**-Labs (TB within 1 year)**
**-Copy of Insurance Card**
**-MD notes**

We will notify you within 24 hours, once this referral is received

If you do not receive a confirmation please call 1.800.734.2896 or re-fax the referral to 559.734.6451

**Thank you for the opportunity to assist in the care of your patient**

### PHYSICIAN ORDER IMMUNE GLOBULIN

**Loading Dose Immune Globulin**

○ _____ gm/kg or _____ gm

**Maintenance Dose Immune Globulin**

○ _____ gm/kg or _____ gm

every _____ week x _____ cycle(s)

○ Other _____

○ Infusion Rate over 2 1/2-5 hours, titrate up as tolerated via Curlin pump

**Has patient received immune globulin previously?**

○ Yes
○ No

**Administration**

○ **IVIG (Intravenous)**
○ **SQIG (Subcutaneous)**
○ Other _____

**IV Access**

○ Port
○ Peripheral

○ Pre-medication
Acetaminophen 650mg PO 15-30 minutes before infusion
Diphenhydramine 25mg PO 15-30 minutes before infusion
Aspirin 81 mg PO 15-30 minutes before infusion
Other _____

○ As Needed Meds
NS 1 liter IV daily over 4-6 hours on IVIG days
Ondansetron 8mg (add to NS bags for N/V)
Ondansetron 4mg IV push Q4-6 hours PRN N/V over 1-2 minutes
Hydrocortisone 1% cream as directed for SQIG

○ Anaphylactic Kit:
Epipen 0.3mg 2pk auto injector as directed
Diphenhydramine 12.5 mg tab #4
Diphenhydramine 50 mg/ml vial #2 as directed

○ Skilled nursing as needed for teaching & administration

**I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment**

**Physician Signature** **Date**