RELIANT SPECIALTY INFUSION

AIC Dermatology **Fax: 833-808-0833**

Patient Information

Patient Name: _____ DOB: _____ Height: _____ Weight: _____ Patient Contact #: _____

Medical Assessment

- **Diagnosis:** □ L40.8 Plaque Psoriasis □ L40.50 Psoriatic Arthritis □ Other: _____
- **Drug Allergies:** _____
- **Failed Medications:** When_____□ Soriatane _ □ MTX _____ □ Biologics ____
  □ PUVA / UVB _____ □ Topicals _____ □ Other _____
- **Negative TB Skin Test (PPD Test):** □ Yes □ No When: _____ (Please Attach)
- **Location:** % BSA:_____ □ Hands □ Feet □ Scalp □ Groin □ Nails □ Other: _____

****Please include a demographics page, front and back of an insurance card, any clinical notes with supporting diagnosis, lab-work, tests, and any other supporting documentation including past tried and / or failed therapies associated with diagnosis****

Labwork: _____ To be Drawn by: □ Infusion Clinic □ Referring Provider

Pre-Medication Orders:

- ❑ APAP □ 325mg □ 500mg □ 650mg - PO 30 minutes before infusion.
- ❑ Diphenhydramine □ 25mg □ 50mg – PO 30 minutes before infusion.
  □ 25mg IVP □ 50mg IVP
- ❑ Alternate Oral Antihistamines: □ Cetirizine 10mg □ Loratadine 10mg □ Fexofenadine 60mg or □180mg
- ❑ Methylprednisolone □ 40mg IVP □ 125mg IVP or other ____ mg IVP
- ❑ Famotidine □ 20mg PO □ 40mg PO □ 20mg IVP □ 40mg IVP
- ❑ Ondansetron □ 4 mg IVP □ 4 mg PO

Medication

Cimzia (certolizumab pegol) – *AIC / HCP office administration injection only*

Dosage / Frequency:

- ❑ 400mg SC injection every other week (administered as 2 divided injections to separate sites in abdomen or thigh only)
- ❑ Other: _____ **Maintenance Refills**: ___

Infliximab (Remicade & Biosimilars)

- ❑ ***Preferred* - Infusion Clinic Preference (Remicade / Avsola / Renflexis) based on payer directives / availability.**
- ❑ **Specific Product: _____**

Dosage:

- ❑ 5 mg /kg per 250 ml sodium chloride 0.9% IV to infuse over at least 2 hours, or
- ❑ Other Dosage: ____mg or ___mg / kg per 250-500ml sodium chloride 0.9% IV

Frequency:

- ❑ Induction orders to be completed at week 0, 2, and 6 weeks and then every 8 weeks thereafter
- ❑ Orders every 8 weeks (maintenance) **Maintenance Refills: ___**
- ❑ Other orders: _____

Ilumya (tildrakizumab-asmn) - *AIC / HCP office administration injection only*

Dosage / Frequency:

- ❑ Induction: Ilumya 100mg / ml injection at week 0 and 4, then every 12 weeks thereafter.
- ❑ Maintenance: 100 mg/ml injection every 12 weeks **Maintenance Refills**: ___

Simponi Aria (golimumab)

Dosage / Frequency:

- ❑ Induction: 80 mg IV infusion over 30 minutes at weeks 0 and 4, then every 8 weeks thereafter.
- ❑ Maintenance: Orders to be completed every 8 weeks. **Maintenance Refills**: ___
- ❑ Other: _____

Spevigo (spesolimab-sbzo)

Dosage / Frequency:

- ❑ 900 mg IV infusion as a single dose over 90 minutes **Maintenance Refills: __**

Physician Prescription Orders

Address: _____ Phone: _____

Fax: _____ Clinic Contact: _____Physician Name: _____

NPI #_____***Physician Signature:*** _____***Date:*** _____