

DERMATOLOGY ENROLLMENT FORM

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* Patient Name: _____ *DOB: / / Height: _____ *Weight: _____ kg Date: / /
 Allergies: _____ Email: _____ Ship to: Patient
 Address: _____ Ph: _____ * Prescriber Signature MD Office
 * Prescriber: _____ Ph: _____ Fax: _____ Althea Location: _____

- ### DOCUMENTS TO INCLUDE WITH REFERRAL
- * Patient demographics
 - * Copies of insurance card (front and back)
 - * Pharmacy Card
 - * **Recent Lab Results:** CBC with differential, CMP, Hepatitis B & C, TB Screening (Quantiferon or TST), HIV screening
 - * Specialist consults and recent progress notes
 - * Prior medications and therapies (failed or inadequate response)
 - * Relevant imaging studies (MRI, CT, X-ray, etc.)
 - * Baseline functional assessment with detailed symptom history

- ### DIAGNOSIS
- L40.0 – Plaque Psoriasis, Moderate to Severe
 - L40.50 – Psoriatic Arthritis
 - L40.59 – Psoriasis with Arthropathy
 - L20.9 – Atopic Dermatitis (Eczema), Moderate to Severe
 - L73.2 – Hidradenitis Suppurativa (HS)
 - L10.0 – Pemphigus Vulgaris
 - L63.9 – Alopecia Areata, unspecified
 - L28.1 – Prurigo Nodularis
 - L50.1 – Chronic Idiopathic Urticaria
 - L94.0 – Localized Scleroderma / Morphea
 - Other: _____

IMMUNE GLOBULIN PRESCRIPTION (IVIG)

Loading Dose: _____ grams/kg infused over _____ day(s)
 _____ grams daily for _____ day(s)

Maintenance: _____ grams/kg infused over _____ day(s)
 _____ grams daily for _____ day(s)

Repeat course every _____ week(s) refill x 1 year

SUBCUTANEOUS IMMUNE GLOBULIN PRESCRIPTION (SCIG):

SCIG _____ grams monthly **OR** _____ grams every _____ weeks.
 Refill x 1 year. Pharmacy to select number of infusion sites and needle length.

Brand Name: _____ Multiple doses will be administered on consecutive days unless ordered otherwise. **Non-consecutive days OK** OK to round to the nearest vial size +/- 4 days to allow scheduling flexibility.

DERMATOLOGY PRESCRIPTION	DOSAGE AND ADMINISTRATION
Cosentyx® (secukinumab)	Plaque Psoriasis: 300 mg SC at weeks 0, 1, 2, 3, and 4; then 300 mg SC every 4 weeks. HS: 300 mg SC weekly for 5 weeks, then 300 mg SC every 4 weeks. Psoriatic Arthritis: 150 mg SC at weeks 0, 1, 2, 3, and 4; then 150 mg SC every 4 weeks.
Dupixent® (dupilumab)	Atopic Dermatitis (adults): 600 mg SC (two 300 mg injections) initially, then 300 mg SC every other week. Atopic Dermatitis (6–17 yr, weight-based): See prescribing information for pediatric dosing. Prurigo Nodularis: 600 mg SC initially, then 300 mg SC every other week
Humira® (adalimumab) / Biosimilars	Plaque Psoriasis: 80 mg SC initially, then 40 mg SC every other week starting 1 week after initial dose. HS: 160 mg SC Day 1, 80 mg SC Day 15; then 40 mg SC weekly starting Day
Rituxan® (rituximab) Ruxience® (rituximab-pvvr) Truxima® (rituximab-abbs)	Pemphigus Vulgaris: 1000 mg IV on Day 1 and Day 15; then 500 mg IV at Month 12 and 6 months.
Skyrizi® (risankizumab-rzaa)	Plaque Psoriasis: 150 mg SC (two 75 mg injections) at weeks 0 and 4, then every 12 weeks. PsA: 150 mg SC at weeks 0 and 4, then every 12 weeks.
Spevigo® (spesolimab-sbzo)	GPP Flare (IV): 900 mg IV over 90 minutes as a single dose. Maintenance (SC): 300 mg SC every 12 weeks.
Taltz® (ixekizumab)	Plaque Psoriasis: 160 mg SC at week 0, then 80 mg SC at weeks 2,4,6,8,10,12; then 80 mg SC every 4 weeks. HS: 160 mg SC at week 0, then 80 mg SC every 4 weeks.
Ilumya® (tildrakizumab-asmn)	1 0209 .mg SC at weeks 0 and 4, then 100 mg SC every 12 weeks.
Other: _____	_____

PREMEDICATION ORDERS/OTHER MEDICATIONS

Flush Protocol - Flushing per S.A.S.H. protocol (Saline, Administer medication, Saline, Heparin) specific volumes and concentrations based on patient's line type.

Premedications & Other Medications - Infusion supplies as per protocol. Anaphylaxis Kit orders as per protocol.

Acetaminophen _____ mg PO prior to infusion Diphenhydramine _____ mg PO
 Methylprednisolone Other: _____