



Jupiter Infusion  
 140 Jupiter Lakes Blvd, Suite A  
 Jupiter, FL 33458  
 Office: 561-277-9211

## Dermatology Order Form

**PATIENT INFORMATION:** Fax completed form, insurance information, and clinical documentation to 561-277-9226

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_

**MEDICAL INFORMATION**

Patient Weight: \_\_\_\_\_ lbs./kg. (required) Allergies: \_\_\_\_\_

**THERAPY ORDER**

Diagnosis	Medication Orders	Refills
<input type="checkbox"/> Dermatomyositis <input type="checkbox"/> Dermatopolymyositis <input type="checkbox"/> Pemphigoid/Pemphigus ICD-10: _____	<b>IVIg Orders:</b> _____ mg/kg <b>OR</b> _____ gm/kg IV x _____ day(s) <b>OR</b> divided over _____ days(s) <b>Frequency:</b> Every _____ weeks <b>OR</b> _____ <b>Preferred brand:</b> _____ (Active Infusions to choose if not indicated) <b>Additional Ig orders:</b> _____	<input type="checkbox"/> x 1 year <input type="checkbox"/> _____
<input type="checkbox"/> Chronic Idiopathic Urticaria (CIU) ICD-10: _____	<b>Xolair</b> <input type="checkbox"/> 150mg SQ every 4 weeks <b>OR</b> <input type="checkbox"/> 300mg SQ every 4 weeks <b>REQUIRED: Patient must have an EpiPen in their possession on their appointment date</b>	<input type="checkbox"/> x 1 year <input type="checkbox"/> _____
<input type="checkbox"/> Pemphigus Vulgaris ICD-10: _____	<input type="checkbox"/> <b>Rituximab or rituximab biosimilar</b> (as required by patient's insurance) <input type="checkbox"/> Do not substitute. Infuse the following rituximab product: _____ Initial Dose: <input type="checkbox"/> 1000mg IV at day 0, 15 days Maintenance Dose: <input type="checkbox"/> 500mg IV at month 12 and every 6 months thereafter Other dose: _____ <b>Protocol Premedication Orders: Solu-Medrol 100mg IV, Tylenol 1000mg PO, and Benadryl 50mg PO/IV</b>	<input type="checkbox"/> X 1 year <input type="checkbox"/> _____
<input type="checkbox"/> Psoriatic Arthritis <input type="checkbox"/> Psoriasis <input type="checkbox"/> Plaque Psoriasis ICD-10: _____	<input type="checkbox"/> <b>Infliximab or infliximab biosimilar</b> (as required by patient's insurance) <input type="checkbox"/> Do not substitute. Infuse the following infliximab product: _____ <b>Dose:</b> _____ mg/kg <b>Frequency:</b> <input type="checkbox"/> Every _____ weeks <b>OR</b> <input type="checkbox"/> 0, 2, 6, then every 8 weeks  <b>Simponi Aria</b> Initial Dose: <input type="checkbox"/> 2mg/kg IV at weeks 0, 4, and then every 8 weeks Maintenance Dose: <input type="checkbox"/> 2mg/kg IV every 8 weeks  <b>Stelara</b> <input type="checkbox"/> 45mg SQ initially and 4 weeks later followed by 45mg SQ every 12 weeks (<100kg) <input type="checkbox"/> 90mg SQ initially and 4 weeks later followed by 90mg SQ every 12 weeks (>100kg) Maintenance Dose: <input type="checkbox"/> 45mg SQ every 12 weeks <b>OR</b> <input type="checkbox"/> 90mg SQ every 12 weeks  <b>Ilumya</b> Initial Dose: <input type="checkbox"/> 100mg SQ at weeks 0, 4, and every 12 weeks thereafter Maintenance Dose: <input type="checkbox"/> 100mg SQ every 12 weeks  <b>Cimzia</b> <input type="checkbox"/> 200mg SQ every 2 weeks <b>OR</b> <input type="checkbox"/> 400mg SQ every 4 weeks <b>OR</b> <input type="checkbox"/> 400mg SQ every 2 weeks <input type="checkbox"/> 400mg SQ at weeks 0, 2, and 4 followed by: <input type="checkbox"/> 200mg <b>OR</b> <input type="checkbox"/> 400mg every 2 weeks	<input type="checkbox"/> x 1 year <input type="checkbox"/> _____
<input type="checkbox"/> Generalized Pustular Psoriasis ICD-10: _____	<input type="checkbox"/> <b>Spevigo</b> 900mg IV x 1 <input type="checkbox"/> Repeat Spevigo 900mg IV in 1 week if symptoms persist	
<b>Premedication orders:</b> Tylenol <input type="checkbox"/> 1000mg <b>OR</b> <input type="checkbox"/> 500 mg PO Please choose one antihistamine: <input type="checkbox"/> Diphenhydramine 25mg PO <input type="checkbox"/> Loratadine 10mg PO <input type="checkbox"/> Cetirizine 10mg PO <input type="checkbox"/> Other: _____ Additional premedications: <input type="checkbox"/> Solu-Medrol _____ mg IVP <input type="checkbox"/> Solu-Cortef _____ mg IVP <input type="checkbox"/> Other: _____		

Please provide patient's demographic information, insurance information, medication list, and clinical notes. JUPITER INFUSION will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and assist them in enrolling in any available co-pay assistance programs as needed/applicable. Thank you for the referral.

**PROVIDER INFORMATION**

Provider Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Contact Person: \_\_\_\_\_