Dermatology Therapies

Referring Physician Orders Rev. 06.2025

Please fax completed referral form & all required documents to 208-595-4427

PATIENT DEMOGRAPHICS

Patient Name: _____ DOB: _____ Phone: _____

Address: _____ City/ST/Zip: _____

Allergies: _____ ☐ NKDA Weight: _____ ☐ lbs ☐ kg Height: _____ ☐ in ☐ cm

INSURANCE INFORMATION: ***Please attach copy of insurance card (front and back).***

DIAGNOSIS*

ICD 10 Code Required

☐ Plaque Psoriasis (L40.0-L40.9), ICD10 _____

☐ Idiopathic Urticaria, ICD10 L50.1

☐ Other: _____, ICD10 _____

INFUSION ORDERS

MEDICATION	DOSE	DIRECTIONS/DURATION
Cimzia® (certolizumab pegol)	☐ **INITIAL:** 400mg ☐ **MAINTENANCE:** ☐ 400mg ☐ 200mg	☐ **INITIAL:** Inject 400mg SUBQ at Weeks 0, 2, 4, then every 4 weeks x 1 year ☐ **MAINTENANCE:** Inject 400mg SUBQ every 4 weeks x 1 year ☐ **MAINTENANCE:** Inject 200mg SUBQ every 2 weeks x 1 year
Ilumya® (tildrakizumab)	100mg	☐ **INITIAL:** Inject SubQ at Weeks 0 and 4, then every 12 weeks x 1 year ☐ **MAINTENANCE:** Inject SubQ at every 12 weeks x 1 year
Xolair® (omalizumab)	☐ 100mg ☐ 300mg	☐ Inject SUBQ every _____ weeks x 1 year ☐ New patient: Observe patient for 2 hours following first Xolair doses, and then for 30 minutes after all subsequent doses. ☐ Established patient: Observe patient for 30 minutes after each dose.

Is patient currently receiving therapy above from another facility? ☐ **NO** ☐ **YES**

If yes, Facility Name: _____ Date of last treatment: _____ Date of next treatment: _____

OTHER ORDERS

LAB ORDERS: Labs to be drawn by: ☐ Infusion Center ☐ Referring Physician

☐ No labs ordered at this time

☐ CBC q _____ ☐ CMP q _____ ☐ CRP q _____ ☐ ESR q _____ ☐ LFTs q _____ ☐ Other: _____

PRE-MEDICATION ORDERS:

☐ No premeds ordered at this time

☐ Acetaminophen 650mg PO

☐ Diphenhydramine 25mg PO

☐ Methylprednisolone 40mg IVP -OR- ☐ Hydrocortisone 100mg IV

☐ Other: _____

REFERRING PHYSICIAN INFORMATION

Physician Signature: _____ Date: _____

Physician Name: _____ Provider NPI: _____ Specialty: _____

Address: _____ City/ST/Zip: _____

Contact Person: _____ Phone #: _____ Fax #: _____

Email Where Follow Up Documentation Should Be Sent: _____

REQUIRED CLINICAL DOCUMENTATION

Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis.

Clinical Information, select all that apply:

For Plaque Psoriasis:

☐ The patient has moderate-to-severe chronic plaque psoriasis affecting at least 3% of the body surface area (BSA) or involves sensitive areas that impact daily function (e.g., palms, soles of feet, head/neck, or genitalia).

☐ Patient has had an inadequate response to or is intolerant to phototherapy, topical therapies, or other systemic therapies.

For CIU:

☐ Patient has had urticaria for at least 6 weeks.

LAB AND TEST RESULTS for PLAQUE PSORIASIS (required)

- TB screening for Cimzia and Ilumya (submit results from within 12 months to start therapy and annually to continue therapy)
  - Annual TB screening to be done by: ☐ Infusion Center ☐ Referring Physician
- Hepatitis B Screening for Cimzia (submit results to start therapy)

LAB AND TEST RESULTS for URTICARIA (required)

☐ Baseline Urticaria Activity Score

PRIOR FAILED THERAPIES

Medication: _____ Dates of Treatment: _____ Reason for D/C: _____

Medication: _____ Dates of Treatment: _____ Reason for D/C: _____

Medication: _____ Dates of Treatment: _____ Reason for D/C: _____

Medication: _____ Dates of Treatment: _____ Reason for D/C: _____