

Patient Information

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

Medical Assessment

- **Diagnosis:** ☐ L40.1 Generalized Pustular Psoriasis ☐ 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 OR ☐ 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 OR _____
- Maintenance Refills:**
- _____

Infliximab (Remicade & Biosimilars)

- ☐
- Preferred - Infusion Clinic Preference (Remicade / Avsola / Renflexis) based on payer directives / availability.)**

- ☐
- Specific Product:**
- _____

Dosage (choose one): 5 mg /kg OR _____mg or _____mg / kg

Frequency:

- ☐
- Induction dose at weeks 0, 2, and 6

- ☐
- Maintenance: (choose one) _____every 8 weeks OR every _____

Maintenance Refills: _____**Ilumya (tildrakizumab-asmn) - AIC / HCP office administration injection only**

Dosage / Frequency:

- ☐
- Induction: 100mg at week 0 and 4

- ☐
- Maintenance: 100 mg at week 16 and every 12 weeks thereafter

Maintenance Refills: _____**Simponi Aria (golimumab)**

Dosage / Frequency:

- ☐
- Induction: 80 mg IV at weeks 0 and 4

- ☐
- Maintenance: 80 mg IV at week 12 and every 8 weeks thereafter

- ☐
- Other: _____

Maintenance Refills: _____**Spevigo (spesolimab-sbzo)**

Dosage / Frequency:

- ☐
- 600 mg SQ on week 0 then 300 mg SQ on week 4 and every 4 weeks thereafter

- ☐
- 900 mg IV infusion as a single dose

Maintenance Refills: _____**Tremfya (guselkumab)**

Dosage/Frequency:

- ☐
- 100mg SC at weeks 0, 4, and every 8 weeks thereafter

Maintenance Refills: _____**Physician Prescription Orders**

Address: _____ Phone: _____

Fax: _____ Clinic Contact: _____ Physician Name: _____

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