axiva

Dermatology
Patient Referral Form

Infusion Specialist
c:
e:

PATIENT INFORMATION

Date: Patient Name: Last 4 SSN DOB:

Address: City: ST: Zip:

Primary Phone: Work Phone:

Gender: ☐M ☐F Weight lbs/kg: Height: Allergies:

Primary Insurance: **Secondary Insurance:**

Member#: **Group#:** **Member#:** **Group#:**

Diagnosis: _____

Documentation needed: ☑ Insurance cards ☑ Most recent clinical including H&P ☑ Labs ☑ Diagnostic testing results

Medication	Order
Cimzia – Subcutaneous or IV (suite only)	☐ Initial: 400 mg week 0, week 2, week 4, then maintenance ☐ Maintenance: 400 mg every 2 weeks ☐ Other: ☐ Sub-Q ☐ IV (Suite Only)
Dupixent - Subcutaneous	☐ Initial: 600 mg sub-Q, then maintenance ☐ Maintenance: ☐ 300 mg Freq: ☐ Every 2 weeks ☐ _____ mg ☐ Every 4 weeks
Enbrel - Subcutaneous	☐ 50 mg sub-Q ____ weekly ☐ Other:
Humira - Subcutaneous	☐ Induction: 160 mg sub-Q day 1, 80 mg day 15 ☐ Maintenance: 80 mg sub-Q every other week ☐ Induction: 80 mg sub-Q day 1, 40 mg day 8, 40 gm day 22 ☐ Maintenance: 40 mg sub-Q every other week ☐ Other:
Ilumya - Subcutaneous	☐ Initial: 100 mg sub-Q week 0 and week 4, then maintenance ☐ Maintenance: 100 mg sub-Q every 12 weeks
Infliximab - IV ☐ Remicade ☐ Inflectra ☐ Renflexis	☐ 5 mg/kg Freq: ☐ Initial: week 0, week 2, week 6, then maintenance ☐ _____ mg/kg ☐ Maintenance: Every 8 weeks ☐ _____ mg ☐ Every _____ weeks
Rituximab - IV ☐ Rituxan ☐ Truxima ☐ Ruxience	☐ Initial: 1000 mg day 1 and day 15, then maintenance ☐ Maintenance: 500 mg (starting at month 12 from start) every 6 months ☐ Other:
Simponi - Subcutaneous	☐ 50 mg sub-Q every 4 weeks ☐ Other:
Simponi Aria - IV	☐ Initial: 2 mg/kg week 0 and 4, then maintenance ☐ Other: ☐ Maintenance: Every 8 weeks ☐ Other:

FAX completed form to Axiva 844.440.0101 **Intake Specialist: 844.44-AXIVA (844.442.9482)**

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Skyrizi - Subcutaneous	☐ Initial: 150 mg sub-Q week 0 and week 4, then maintenance ☐ Maintenance: 150 mg sub-Q every 12 weeks
Stelara - Subcutaneous	☐ Initial: 45 mg week 0 and week 4, then maintenance ☐ Initial: 90 mg week 0 and week 4, then maintenance ☐ Maintenance: every 12 weeks ☐ Other:
Tremfya - Subcutaneous	☐ Initial: 100 mg sub-Q week 0 and week 4, then maintenance ☐ Maintenance: 100 mg sub-Q every 8 weeks
Xeljanz - Oral	☐ 5 mg PO twice daily ☐ 11 mg XR PO once daily ☐ Other:

Nursing

☑ Establish and/or maintain access device as needed for dose administration
☑ Administer by ordered route
☑ Obtain vital signs prior to, throughout as directed and at completion of infusion
☑ If reaction occurs follow procedure reaction management

PROVIDER INFORMATION

By signing I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment. Axiva Health Solutions, Inc., has my permission to contact the patient's health plan to obtain authorizations necessary to enable it to receive payment for services.

Physician Name: NPI: DEA: License:

Address: City: ST: Zip:

Phone: Fax: Office Contact:

_____ _____ ♦ _____ _____

Physician Signature Required – Substitution Permitted Date Physician Signature Required – Dispense as Written Date

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