Dermatology Medication Form

Updated 9/1/2026

Patient Name: _____

DOB: _____ **Phone Number:** _____

Height: _____ **Weight:** _____ **Allergies:** _____

Please fax copy of patient's insurance and demographic information

BURNHAM'S vitalcare

Diagnosis: ☐ Plaque Psoriasis L40.0 ☐ Psoriatic Arthritis L40.5 ☐ Other: _____

TB/PPD test given? Yes / No **Hepatitis B** Surface Antigen & Core AB? Yes / No ■ Vital Care can draw TB and Hep B labs as indicated by therapy if results not available.

Medication	Directions	Refills
IVIG	☐ **Loading:** IVIG _____ mg/kg (_____ mg) IV x _____ day(s) or divided over _____ day(s) ☐ **Maintenance:** IVIG _____mg/kg (or _____mg) IV x _____day(s) or divided over _____ day(s) **Frequency:** ☐ Every _____ weeks ☐ One time only dose ■ Pharmacist to choose clinically appropriate brand/infusion rate unless otherwise specified here: _____	**1 year** **Or _____**
Infliximab	☐ **Initial Loading Doses:** Infuse _____ mg/kg (_____ mg) IV at weeks 0, 2, and 6 weeks. ☐ **Maintenance Doses:** Infuse _____ mg/kg (_____ mg) IV every _____ weeks. ■ Pharmacist to choose clinically appropriate infliximab or biosimilar unless otherwise specified here: _____ ■ CBC and LFTs to be drawn by Vital Care as needed if results not available from clinic.	**1 year** **Or _____**
Simponi Aria	☐ **Initial Loading Doses:** Infuse 2mg/kg (_____ mg) IV at weeks 0 and 4. ☐ **Maintenance Doses:** Infuse 2mg/kg (_____ mg) IV every 8 weeks.	**1 year** **Or _____**
Stelara	☐ **Patients weighing <100kg**, 45mg SubQ initially and 4 weeks later, followed by 45mg every 12 weeks. ☐ **Patients weighing >100kg**, 90mg SubQ initially and 4 weeks later, followed by 90mg every 12 weeks. ☐ **Other:** _____ ■ Pharmacist to choose clinically appropriate brand/infusion rate unless otherwise specified here: _____	**1 year** **Or _____**
Tremfya	☐ **Loading Doses:** 100mg subcutaneously at week 0, week 4 and then every 8 weeks. ☐ **Maintenance Doses:** 100mg subcutaneously every 8 weeks.	**1 year** **Or _____**
Cimzia	**Initial Loading Doses:** ☐ 400mg SubQ at weeks 0, 2 and 4. **Maintenance Doses:** ☐ 200mg SubQ every _____ weeks for _____ weeks. ☐ 400mg SubQ every _____ weeks for _____ weeks.	**1 year** **Or _____**
Ilumya	**Induction Doses:** ☐ 100mg SubQ injection at week 0 and week 4 **Maintenance only:** ☐ 100mg SubQ injection every 12 weeks	**1 year** **Or _____**

Additional Orders

Pre-Medication Orders: To be given 30 minutes prior to each infusion PRN

☐ Tylenol 650mg PO ☐ Cetirizine 10mg PO ☐ Diphenhydramine 25mg PO ☐ Loratadine 10mg PO

☐ Solu-Medrol _____ mg IVP ☐ Solu-Cortef _____ mg IVP ☐ Other: _____ ■ Anaphylaxis kit to be sent with all new therapies.

Lab Orders: _____ **Frequency:** _____

Labs to be drawn by: ☐ Vital Care ☐ Prescriber's Office

Additional Orders/Notes:

Provider Information

Prescriber Name:	NPI:	Phone:
Signature:	Date:	Fax:

I authorize Vital Care Infusion Services and its representatives to initiate any prior authorization process that is required for this prescription and for any future refills of the same prescription for the patient listed above which I order. I understand that I can revoke this designation at any time by providing written notice to Vital Care.

Fax patient demographics, insurance info, office notes, diagnostic testing and labs to (228) 474-5544