



Patient Information	Prescriber Information
Name:	Prescriber Name:
DOB:	NPI:
Address:	Address:
City: State:	City:
Zip: Weight:	State: Zip:
Phone:	Phone:
Allergies:	Fax:

Diagnosis (please provide ICD-10 code in space provided):			
Plaque Psoriasis	Psoriatic Arthritis	Psoriasis	Sarcoidosis
Pemphigus vulgaris	Psoriatic spondylitis		Other

Nursing Orders: Hold infusion and notify provider for:

Signs/symptoms of illness or active infection, planned/recent surgical procedures, cough, night sweats, unintended weight loss, recent live vaccinations, active shingles.

If infusion related reaction occurs, stop infusion and follow Hypersensitivity Reaction Management Policy/Protocol as clinically indicated

Drug	Dosing
Cimzia (certolizumab pegol)	☐ 400mg SubQ at weeks 0, 2, and 4, followed by ☐ 200mg ☐ 400mg every 2 weeks ☐ 200mg SubQ every 2 weeks ☐ 400mg SubQ every 4 weeks ☐ 400mg SubQ every 2 weeks
Ilumya (tildrakizumab)	Initial Dose: ☐ 100mg SQ at weeks 0, 4, and every 12 weeks thereafter Maintenance Dose: ☐ 100mg SQ every 12 weeks
☐ Infliximab or Infliximab biosimilar (as required by patient's insurance) ☐ Do not substitute. Infuse the following infliximab product:	Dose: mg/kg IV Frequency: ☐ 0, 2, 6 then every 8 weeks ☐ Every weeks For Allied use only. Brand:
☐ Rituximab or rituximab biosimilar (as required by patient's insurance) ☐ Do not substitute. Infuse the following rituximab product:	Initial Dose: ☐ 1000mg IV at day 0, 15 days Maintenance Dose: ☐ 500mg IV at month 12 and every 6 months thereafter Other dose: For Allied use only. Brand: Pre-med Orders: Solu-Medrol 100mg IV, acetaminophen 1000mg PO, and diphenhydramine 50mg PO or IV
Simponi Aria (golimumab)	Initial Dose: ☐ 2mg/kg IV at weeks 0, 4 and then every 8 weeks Maintenance Dose: ☐ 2mg/kg IV every 8 weeks
Spevigo (spesolimab)	☐ 900mg IV x 1 ☐ Repeat Spevigo 900mg IV in 1 week if symptoms persist
☐ Ustekinumab or ustekinumab biosimilar (as required by patient's insurance) ☐ Do not substitute. Give the following ustekinumab product:	☐ 45mg SubQ initially and 4 weeks later, followed by 45mg every 12 weeks (≤ 100 kg) ☐ 90mg SubQ initially and 4 weeks later, followed by 90mg every 12 weeks (> 100 kg) Maintenance Dose: ☐ 458mg SQ every 12 weeks ☐ 90mg SQ every 12 weeks For Allied use only. Brand:
Xolair (omalizumab)	☐ 150mg ☐ 300mg ☐ mg SubQ every 4 weeks Note: Patient must have an EpiPen in their possession on their appointment date

Premedications:
☐ Tylenol 650mg PO ☐ Benadryl 25mg IV or PO ☐ Solu-Medrol IV 40mg, 125mg or mg
☐ Other: IV or PO
Order valid for one year unless otherwise indicated. IV solutions and diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.

Prescriber Name (Please print): Contact Person:
Prescriber Signature: Date:

Please include a copy of the latest insurance information as well as all applicable clinical notes.

By signing this form, you certify that the use of the selected treatment is medically necessary and you will be supervising the treatment of the patient. Additionally, you authorize Allied Infusion Services to act as your prior authorization designated agent when interacting with medical and prescription payors and patient assistance programs.