

Rheumatology Referral Form



Fax Completed Form To:

Phone:

PATIENT INFORMATION			
Patient Name:	Date of Birth:	Referral Date:	
Address:		City/State/Zip:	
Home Phone:	Cell Phone:	Work Phone:	
Secondary Contact:	Height:	Weight:	Male Female
Patient Diagnosis & ICD-10:			
Allergies:			

PROVIDER INFORMATION			
Physician Name:	Lic.#:	DEA #:	
Practice Name:		NPI#:	
Address:		City/State/Zip:	
Office Contact:	Phone:	Fax:	
Supervisory Physician (if applicable):			

PLEASE ATTACH	
Patient demographics & front/back copy of all insurance cards (prescription & medical) Recent office visit notes, history & physical, lab & pertinent procedure results Current medication list & list of prior medications tried and failed (with dates) HBV lab results within last 12 months (<i>Infliximabs only, Orencia & Actemra only</i>)	TB lab results within last 12 months (<i>except for Prolia/Evenity</i>) Absolute neutrophil count (ANC), platelet count, ALT and AST lab results (<i>Actemra only</i>) Letter of medical necessity if drug dosing or indication is outside of FDA guidelines

NURSING & LAB ORDERS	
Nurse Orders: Nurse to provide assessment, teaching, lab draws, medication administration and vascular access device insertion and/or management per physician orders.	
Flush Orders: NaCl 0.9% - 5-10mL flush pre and post infusion and as needed Heparin - 10units/mL ---OR--- 100units/mL - 3-5mL flush after post-infusion NS flush if indicated to maintain line	
Lab Orders: Lab Date & Frequency:	

PRESCRIPTION ORDERS			
Anaphylaxis Kit:	Epinephrine 0.3mg IM as needed	Solu-cortef 250mg-500mg IV infusion as needed	Solu-Medrol 60mg - 125mg IV infusion as needed
(Check all that apply)	Diphenhydramine _____ mg IV infusion as needed	NS Hydration 500 ml IV infusion over 30 minutes as needed	Other _____
Pre-Medications:	Acetaminophen _____ mg PO _____ minutes prior to infusion	Solu-Medrol _____ mg IV infusion _____ minutes prior to infusion	
(Check all that apply)	Diphenhydramine _____ mg PO ---OR--- IV infusion _____ minutes prior to infusion	Other _____	

Supply Orders: All supplies for vascular access line care, drug administration kit(s), pump, and IV pole will be provided as necessary

PRODUCT	PRESCRIPTION INFORMATION	REFILLS
Is this a first dose?	Yes No If No, when was last dose given? _____ When is patient due for next dose? _____	
ACTEMRA	Induction: 4mg/kg IV infusion via gravity- ---OR--- pump over at least 1 hour every ____ weeks Maintenance: IV infusion of 4mg/kg 6mg/kg 8mg/kg 10mg/kg 12mg/kg _____mg/kg (max of 800mg) via gravity- ---OR--- pump over at least 1 hour Every week (patients >100kg or based on clinical response) 2 weeks (patients <100kg) Other: _____ Round up to nearest whole vial (must choose for Medicaid patients) Give exact dose	NONE
COSENTYX	Induction: 6mg/kg IV infusion over at least 30 minutes at week 0 Dosing Weight: _____ Dose: _____ Maintenance: 1.75mg/kg IV infusion over at least 30 minutes every ____ weeks Dosing Weight: _____ Dose: _____	NONE
EVENTY	210mg SC injection monthly (recommended total of 12 doses)	
ILARIS	For Stills Disease including Adult Onset Stills Disease and Systemic Juvenile Idiopathic Arthritis 4mg/kg SC injection (max of 300mg) for patients ≥ 7.5kg every 4 weeks For Cryopyrin-Associated Periodic Syndromes (CAPS) 150mg SC injection for patients >40kg every 8 weeks 2mg/kg 3mg/kg SC injection for patients 15kg-40kg every 8 weeks	
INFLIXIMAB Avsola Inflixtra Remicade Renflexis	Induction: 3mg/kg 5mg/kg 7.5mg/kg 10mg/kg or _____ mg IV infusion via gravity- ---OR--- pump over at least 2 hours at weeks 0, 2, and 6 Maintenance: 3mg/kg 5mg/kg 7.5mg/kg 10mg/kg _____ mg IV infusion via gravity- ---OR--- pump over at least 2 hours every _____ weeks (Note: Round to nearest 100mg for Medicaid patients) If Remicade infusion tolerated, adjust infusion time according to manufacturer package insert.	NONE
ORENCIA	Induction: _____ mg IV infusion via gravity- ---OR--- pump over at least 30 minutes at week 0, 2 and 4 Maintenance: _____ mg IV infusion via gravity- ---OR--- pump over at least 30 minutes every ____ weeks 10kg to <25kg = 50mg SC injection weekly 25kg to <50kg 87.5 mg SC injection weekly 50kg or more 125mg SC injection weekly	NONE
PROLIA	60mg SC injection every 6 months	
STELARA	Psoriasis Adult Subcutaneous For patients ≤ 100 kg, 45 mg SC injection initially and 4 weeks later, followed by 45 mg every 12 weeks For patients > 100 kg, 90 mg SC injection initially and 4 weeks later, followed by 90 mg every 12 weeks Psoriatic Arthritis Adult 45 mg SC injection initially and 4 weeks later, followed by 45 mg SC injection every 12 weeks For patients with co-existent moderate-to-severe plaque psoriasis weighing >100 kg, 90 mg SC injection initially and 4 weeks later, then every 12 weeks	
KRYSTEXXA	For KRYSTEXXA, please refer to KRYSTEXXA Order Form	RITUXIMAB For RITUXIMAB, please refer to RITUXIMAB Order Form
OTHER		

By signing this form and utilizing our services, you are authorizing Amerita to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature Dispense as Written	Print Name	Date	Prescriber's Signature Substitution Permitted	Print Name	Date
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