

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

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

PRESCRIPTION ORDERS	
<b>Anaphylaxis Kit:</b> <input type="checkbox"/> Epinephrine 0.3mg IM as needed <input type="checkbox"/> Solu-cortef 250mg-500mg IV infusion as needed <input type="checkbox"/> Solu-Medrol 60mg - 125mg IV infusion as needed (Check all that apply) <input type="checkbox"/> Diphenhydramine _____ mg IV infusion as needed <input type="checkbox"/> NS Hydration 500 ml IV infusion over 30 minutes as needed <input type="checkbox"/> Other _____	
<b>Pre-Medications:</b> <input type="checkbox"/> Acetaminophen _____ mg PO _____ minutes prior to infusion <input type="checkbox"/> Solu-Medrol _____ mg IV infusion _____ minutes prior to infusion (Check all that apply) <input type="checkbox"/> Diphenhydramine _____ mg <input type="checkbox"/> PO ---OR--- <input type="checkbox"/> IV infusion _____ minutes prior to infusion <input type="checkbox"/> Other _____	
<b>Supply Orders:</b> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No   If No, when was last dose given? _____ When is patient due for next dose? _____		
<input type="checkbox"/> ACTEMRA	<input type="checkbox"/> <b>Induction:</b> 4mg/kg IV infusion via <input type="checkbox"/> gravity ---OR--- <input type="checkbox"/> pump over at least 1 hour every _____ weeks <input type="checkbox"/> <b>Maintenance:</b> IV infusion of <input type="checkbox"/> 4mg/kg <input type="checkbox"/> 6mg/kg <input type="checkbox"/> 8mg/kg <input type="checkbox"/> 10mg/kg <input type="checkbox"/> 12mg/kg <input type="checkbox"/> _____ mg/kg (max of 800mg) via <input type="checkbox"/> gravity ---OR--- <input type="checkbox"/> pump over at least 1 hour Every <input type="checkbox"/> week (patients >100kg or based on clinical response) <input type="checkbox"/> 2 weeks (patients <100kg) <input type="checkbox"/> Other: _____ <input type="checkbox"/> Round up to nearest whole vial (must choose for Medicaid patients) <input type="checkbox"/> Give exact dose	NONE
<input type="checkbox"/> COSENTYX	<input type="checkbox"/> <b>Induction:</b> 6mg/kg IV infusion over at least 30 minutes at week 0 <b>Dosing Weight:</b> _____ <b>Dose:</b> _____ <input type="checkbox"/> <b>Maintenance:</b> 1.75mg/kg IV infusion over at least 30 minutes every _____ weeks <b>Dosing Weight:</b> _____ <b>Dose:</b> _____	NONE
<input type="checkbox"/> EVENITY	210mg SC injection monthly (recommended total of 12 doses)	
<input type="checkbox"/> ILARIS	<b>For Stills Disease including Adult Onset Stills Disease and Systemic Juvenile Idiopathic Arthritis</b> <input type="checkbox"/> 4mg/kg SC injection (max of 300mg) for patients ≥ 7.5kg every 4 weeks <b>For Cryopyrin-Associated Periodic Syndromes (CAPS)</b> <input type="checkbox"/> 150mg SC injection for patients >40kg every 8 weeks <input type="checkbox"/> 2mg/kg <input type="checkbox"/> 3mg/kg SC injection for patients 15kg-40kg every 8 weeks	
<input type="checkbox"/> INFlixIMAB <input type="checkbox"/> Avsola <input type="checkbox"/> Inflectra <input type="checkbox"/> Remicade <input type="checkbox"/> Renflexis	<input type="checkbox"/> <b>Induction:</b> <input type="checkbox"/> 3mg/kg <input type="checkbox"/> 5mg/kg <input type="checkbox"/> 7.5mg/kg <input type="checkbox"/> 10mg/kg or <input type="checkbox"/> _____ mg IV infusion via <input type="checkbox"/> gravity ---OR--- <input type="checkbox"/> pump over at least 2 hours at weeks 0, 2, and 6 <input type="checkbox"/> <b>Maintenance:</b> <input type="checkbox"/> 3mg/kg <input type="checkbox"/> 5mg/kg <input type="checkbox"/> 7.5mg/kg <input type="checkbox"/> 10mg/kg <input type="checkbox"/> _____ mg IV infusion via <input type="checkbox"/> gravity ---OR--- <input type="checkbox"/> 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
<input type="checkbox"/> ORENCIA	<input type="checkbox"/> <b>Induction:</b> _____ mg IV infusion via <input type="checkbox"/> gravity ---OR--- <input type="checkbox"/> pump over at least 30 minutes at week 0, 2 and 4 <input type="checkbox"/> <b>Maintenance:</b> _____ mg IV infusion via <input type="checkbox"/> gravity ---OR--- <input type="checkbox"/> pump over at least 30 minutes every _____ weeks <input type="checkbox"/> 10kg to <25kg = 50mg SC injection weekly <input type="checkbox"/> 25kg to <50kg 87.5 mg SC injection weekly <input type="checkbox"/> 50kg or more 125mg SC injection weekly	NONE
<input type="checkbox"/> PROLIA	60mg SC injection every 6 months	
<input type="checkbox"/> RITUXIMAB	<input type="checkbox"/> <b>Induction:</b> _____ <input type="checkbox"/> <b>Maintenance:</b> _____	NONE
<input type="checkbox"/> STELARA	<b>Psoriasis Adult Subcutaneous</b> <input type="checkbox"/> For patients ≤ 100 kg, 45 mg SC injection initially and 4 weeks later, followed by 45 mg every 12 weeks <input type="checkbox"/> For patients > 100 kg, 90 mg SC injection initially and 4 weeks later, followed by 90 mg every 12 weeks <b>Psoriatic Arthritis Adult</b> <input type="checkbox"/> 45 mg SC injection initially and 4 weeks later, followed by 45 mg SC injection every 12 weeks <input type="checkbox"/> 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	
<input type="checkbox"/> KRySTEXXA	<b>For KRySTEXXA, please refer to KRySTEXXA Order Form</b>	
<input type="checkbox"/> 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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