

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 (except for Prolia/Evenity)
<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 (Actemra only)
<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 (Infliximab only, Orencia & Actemra only)	

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 - <input type="checkbox"/> 10units/mL ---OR--- <input type="checkbox"/> 100units/mL - 3-5mL flush after post-infusion NS flush if indicated to maintain line	
Lab Orders: Lab Date & Frequency:	

PRESCRIPTION ORDERS	
Anaphylaxis Kit: <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	
Pre-Medications: <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	
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? <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"/> Induction: 4mg/kg IV infusion via <input type="checkbox"/> gravity ---OR--- <input type="checkbox"/> pump over at least 1 hour every ___ weeks <input type="checkbox"/> Maintenance: 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"/> Induction: 6mg/kg IV infusion over at least 30 minutes at week 0 Dosing Weight: _____ Dose: _____ <input type="checkbox"/> Maintenance: 1.75mg/kg IV infusion over at least 30 minutes every ___ weeks Dosing Weight: _____ Dose: _____	NONE
<input type="checkbox"/> EVENITY	210mg SC injection monthly (recommended total of 12 doses)	
<input type="checkbox"/> ILARIS	For Stills Disease including Adult Onset Stills Disease and Systemic Juvenile Idiopathic Arthritis <input type="checkbox"/> 4mg/kg SC injection (max of 300mg) for patients ≥ 7.5kg every 4 weeks For Cryopyrin-Associated Periodic Syndromes (CAPS) <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"/> Induction: <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"/> Maintenance: <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"/> Induction: ___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"/> Maintenance: ___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"/> Induction: <input type="checkbox"/> Maintenance:	NONE
<input type="checkbox"/> STELARA	Psoriasis Adult Subcutaneous <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 Psoriatic Arthritis Adult <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	For KRySTEXXA, please refer to KRySTEXXA Order Form	
<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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