Rheumatology Referral Form

Fax Completed Form To: 877-418-4495 Phone: 877-418-4114

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 *(Infliximabs only, Orencia & Actemra only)*
- TB lab results within last 12 months *(except for Prolia/Evenity)*
- Absolute neutrophil count (ANC), platelet count, ALT and AST lab results *(Actemra only)*
- 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: (Check all that apply)
- Epinephrine 0.3mg IM as needed
- Solu-cortef 250mg-500mg IV infusion as needed
- Solu-Medrol 60mg - 125mg IV infusion as needed
- Diphenhydramine ________ mg IV infusion as needed
- NS Hydration 500 ml IV infusion over 30 minutes as needed
- Other

Pre-Medications: (Check all that apply)
- Acetaminophen ________mg PO ________ minutes prior to infusion
- Solu-Medrol ______mg IV infusion _______minutes prior to infusion
- 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	NONE
	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	___________
COSENTYX	**Induction**: 6mg/kg IV infusion over at least 30 minutes at week 0 **Dosing Weight**:__________ **Dose:** _________	NONE
	Maintenance: 1.75mg/kg IV infusion over at least 30 minutes every ____ weeks **Dosing Weight**:__________ **Dose:** _________	___________
EVENITY	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 Inflectra 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	NONE
	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.	___________
ORENCIA	**Induction:** ______mg IV infusion via gravity-***--OR---*** pump over at least 30 minutes at week 0, 2 and 4	NONE
	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	___________
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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