Rheumatology Referral Form

Amerita
YOUR INFUSION ADVOCATE

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 *(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 (Tocilizumab) ☐ TYENNE (Tocilizumab-aazg) ☐ AVTOZMA (Tocilizumab-anoh)* * interchangeable biosimilar	☐ **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:** _____	
	☐ **Induction/Maintenance**: _____ mg SC at weeks 0, 1, 2, 3, and 4 followed by ____ mg every ____ weeks	_____
☐ 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	_____
☐ RITUXIMAB	☐ **Induction**:	NONE
	☐ **Maintenance**:	_____
☐ KRYSTEXXA	***For KRYSTEXXA, please refer to KRYSTEXXA Order Form***	
☐ OTHER		_____

By signing this form and utilizing our services, you are authorizing Amerita to assist with prior authorization requests acting as your pharmacy provider in dealing with medical and prescription insurance companies.

Prescriber's Signature **Print Name** **Date**
Dispense as Written

Prescriber's Signature **Print Name** **Date**
Substitution Permitted

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THIS FORM IS NOT VALID FOR USE IN THE STATE OF ARIZONA.

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