

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)		☐ TB lab results within last 12 months (except for Prolia/Evenity)	
☐ Recent office visit notes, history & physical, lab & pertinent procedure results		☐ Absolute neutrophil count (ANC), platelet count, ALT and AST lab results (Actemra only)	
☐ Current medication list & list of prior medications tried and failed (with dates)		☐ Letter of medical necessity if drug dosing or indication is outside of FDA guidelines	
☐ HBV lab results within last 12 months (Infliximabs only, Orenzia & 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 - ☐ 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 ☐ 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: _____ ☐ Induction/Maintenance: _____mg SC at weeks 0, 1, 2, 3, and 4 followed by _____mg every _____ weeks		NONE
☐ EVENITY	210mg SC injection monthly (recommended total of 12 doses)		
☐ ILARIS	For Still's Disease including Adult Onset Still's 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 ☐ 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
☐ ORENZIA	☐ 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		
☐ RITUXIMAB	☐ Induction: _____ ☐ Maintenance: _____		NONE
☐ 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
Dispense as Written

Print Name

Date

Prescriber's Signature
Substitution Permitted

Print Name

Date



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