

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) ☐ 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 (<i>Infliximabs only, Orencia & Actemra only</i>)		
☐ TB lab results within last 12 months (<i>except for Prolia/Evenity</i>) ☐ Absolute neutrophil count (ANC), platelet count, ALT and AST lab results (<i>Actemra only</i>) ☐ 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: ☐ Epinephrine 0.3mg IM as needed ☐ Solu-cortef 250mg-500mg IV infusion as needed ☐ Solu-Medrol 60mg - 125mg IV infusion as needed (Check all that apply) ☐ Diphenhydramine _____ mg IV infusion as needed ☐ NS Hydration 500 ml IV infusion over 30 minutes as needed ☐ Other _____ Pre-Medications: ☐ Acetaminophen _____ mg PO _____ minutes prior to infusion ☐ Solu-Medrol _____ mg IV infusion _____ minutes prior to infusion (Check all that apply) ☐ 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 ☐ 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: _____	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
☐ ORENCIA	☐ 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
☐ 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	
☐ 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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Compounding Pharmacy