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|-----------------|--|--------|--|
| Pharmacy Name: | | Phone: | |
| Address: | | Fax: | |
| City/State/Zip: | | Email: | |

Rheumatology Referral Form

****Please Attach Copy of Insurance Cards (Front & Back)****

| | | | |
|------------|-------------|--|-------------------|
| Last Name: | First Name: | DOB: | Practice: |
| Address: | | Address: | |
| City: | State: Zip: | Sex: <input type="checkbox"/> M <input type="checkbox"/> F | City: State: Zip: |
| Phone: | SSN: | Prescriber Name: | |

Insurance Information

| | | |
|-----------------|-----------------|--------------------|
| Insurance Plan: | Insurance Plan: | Prescriber NPI: |
| Policy # | Policy # | Nurse/Key Contact: |
| Plan I.D. # | Plan I.D. # | Phone: Fax: |
| | | Email: |

Diagnosis and Clinical Information

****Please Attach Clinical/Progress Notes, Labs, Test, Supporting Primary Diagnosis****

| | |
|---|---|
| <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Ankylosing Spondylitis <input type="checkbox"/> Gout <input type="checkbox"/> Other: _____ ICD-10: _____ Currently received and/or prior failed therapies: _____ Length of treatment: _____ Reason for discontinuation: _____ | <input type="checkbox"/> Lupus Erythematosus TB/PPD Test: <input type="checkbox"/> Positive <input type="checkbox"/> Negative Date _____ <input type="checkbox"/> Arthritic Psoriasis Hep. B <input type="checkbox"/> Positive <input type="checkbox"/> Negative Date _____ Allergies: _____ <input type="checkbox"/> NKDA Height: _____ Weight: _____ Treatment location: <input type="checkbox"/> Home <input type="checkbox"/> Infusion suite <input type="checkbox"/> Other _____ |
|---|---|

Nursing Orders

Skilled nurse to assess and administer and/or teach self-administration where appropriate. Nurse to provide ongoing support as needed x 1 year.

Prescription Information

| Medication | Dose/Strength | Directions |
|--|--|---|
| <input type="checkbox"/> Remicade (infliximab) | <input type="checkbox"/> 100mg vial | <input type="checkbox"/> INITIAL: Infuse _____ mg/kg IV over 2-3 hours at week 0, 2, 6 then every 8 weeks thereafter <input type="checkbox"/> MAINTENANCE: Infuse _____ mg/kg IV over 2-3 hours every ____ weeks |
| <input type="checkbox"/> Stelara (ustekinumab) | <input type="checkbox"/> 45mg vial | <input type="checkbox"/> INITIAL: 45mg subcutaneously initially, 4 weeks later, followed by 45mg every 12 weeks <input type="checkbox"/> MAINTENANCE: 45mg subcutaneously every 12 weeks <input type="checkbox"/> INITIAL: 90mg subcutaneously initially, 4 weeks later, followed by 90mg every 12 weeks <input type="checkbox"/> MAINTENANCE: 90mg subcutaneously every 12 weeks |
| <input type="checkbox"/> Simponi (golimumab) ARIA | <input type="checkbox"/> 50mg vial | <input type="checkbox"/> INITIAL: 2mg/kg IV at weeks 0, 4, and then every 8 weeks <input type="checkbox"/> MAINTENANCE: 2mg/kg IV every 8 weeks |
| <input type="checkbox"/> Cimzia (certolizumab) | <input type="checkbox"/> 200mg vial | <input type="checkbox"/> INITIAL: 400mg subcutaneously at weeks 0, 2, and 4 weeks <input type="checkbox"/> MAINTENANCE: 200 mg subcutaneously every 2 weeks <input type="checkbox"/> MAINTENANCE: 400 mg subcutaneously every 4 weeks |
| <input type="checkbox"/> Cosentyx (secukinumab) | <input type="checkbox"/> Vial <input type="checkbox"/> Prefilled syringe <input type="checkbox"/> UnoReady pen | <input type="checkbox"/> INITIAL: Infuse 6mg/kg IV at week 0 as loading dose <input type="checkbox"/> MAINTENANCE: 1.75mg/kg IV every 4 weeks (max maintenance dose 300mg per infusion) <input type="checkbox"/> INITIAL: Inject 150mg or 300mg subcutaneously (circle corresponding dose) at weeks 0, 1, 2, 3, and 4. <input type="checkbox"/> MAINTENANCE: 150mg or 300mg subcutaneously (circle corresponding dose) every 4 weeks |
| <input type="checkbox"/> Orencia (abatacept) | <input type="checkbox"/> 250mg vial | <input type="checkbox"/> INITIAL: _____ mg IV Frequency <input type="checkbox"/> Every 4 weeks OR <input type="checkbox"/> 0, 2, 4 weeks and every 4 weeks thereafter |
| <input type="checkbox"/> Krystexxa (pegloticase) | <input type="checkbox"/> 8mg | <input type="checkbox"/> Infuse 8mg IV over 2 hours every 2 weeks |
| <input type="checkbox"/> Tremfya (guselkumab) | <input type="checkbox"/> 100mg/mL prefilled syringe | <input type="checkbox"/> INITIAL: 100mg subcutaneously at week 0 and 4 <input type="checkbox"/> MAINTENANCE: 100mg subcutaneously every 8 weeks thereafter |

Continued on next page.

Nursing Orders

Skilled nurse to assess and administer and/or teach self-administration where appropriate. Nurse to provide ongoing support as needed x 1 year.

Prescription Information, continued

| Medication | Dose/Strength | Directions |
|--|--|--|
| IVIg <input type="checkbox"/> Brand _____ <input type="checkbox"/> Substitution okay | <input type="checkbox"/> 0.4gm/kg <input type="checkbox"/> 1gm/kg <input type="checkbox"/> 2gm/kg <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Daily x _____ day(s) <input type="checkbox"/> Repeat every _____ week(s) x _____ cycles <input type="checkbox"/> Other _____ |
| SCIg <input type="checkbox"/> Brand _____ <input type="checkbox"/> Substitution okay | <input type="checkbox"/> _____ gram(s) <input type="checkbox"/> _____ mg per kg <input type="checkbox"/> _____ grams/kg | <input type="checkbox"/> Once weekly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Other frequency: _____ <input type="checkbox"/> Where clinically appropriate, round to the nearest vial size. |
| <input type="checkbox"/> Rituxan (rituximab) | <input type="checkbox"/> 1000mg <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Dose for RA in combination with methotrexate: two 1,000mg intravenous infusions separated by 2 weeks (one course) every 24 weeks - or based on clinical evaluation, but not sooner than every 16 weeks. Methylprednisolone 100mg intravenous or equivalent glucocorticoid is recommended 30 minutes prior to each infusion. |
| <input type="checkbox"/> Other | | |

Pre-Medication and Other Medications

- * Infusion supplies as per protocol
- * Anaphylaxis kit as per protocol
- Acetaminophen _____ mg PO prior to infusion
- Diphenhydramine _____ mg PO or _____ mL IV prior to infusion
- 0.9% NaCl for hydration _____ mL IV before after medication
- Other _____

Flush Protocol

- NaCl 0.9% 10mL
- Before and after infusion

I authorize Fannin Infusion Pharmacy and its representatives to initiate any insurance prior authorization process that is required for this prescription and for any future refills of the same prescription for the patient listed above which I order. I understand that I can revoke this designation at any time by providing written notice to Fannin Infusion Pharmacy.

Physician Signature: _____

Date: _____

PRESCRIBER MUST MANUALLY SIGN - STAMP SIGNATURE, SIGNATURE BY OTHER PERSONNEL AND COMPUTER-GENERATED SIGNATURES WILL NOT BE ACCEPTED

The attached document(s) contain confidential information which may be considered to be Protected Health Information and therefore required to be maintained as private and secure under HIPAA. The documents may also contain information which is otherwise considered to be privileged under state and federal laws. This communication is for the intended recipient only. If you are not the intended recipient, or a person responsible for delivering this communication to the intended recipient, you are prohibited from viewing, copying and/or distributing the information contained herein. Unlawful disclosure of the information attached may subject you to monetary penalties and sanctions. If you have received this communication in error, you should notify the sender immediately and thereafter permanently destroy all copies of this document in its entirety.

This form is not considered an order or prescription for medical services and/or supplies unless and until it is formally authorized by a healthcare provider in compliance with applicable laws and regulations.

This is not a valid prescription in the state of Arizona.

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