

RHEUMATOLOGY INFUSION Referral Form (Page 1 of 2)

PHONE 515.225.2930 | FAX 515.559.2495



Remove above portion before faxing. Please complete the prescription form in its entirety and fax with secure cover sheet to the number above.

Patient Information

Last Name	First Name	DOB	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Last 4 SSN	Primary Language
Address			City	State	ZIP
Email	Home Phone	Work Phone		Cell Phone	
Primary Contact Method (check one) <input type="checkbox"/> Cell Phone <input type="checkbox"/> Home Phone <input type="checkbox"/> Work Phone <input type="checkbox"/> Text <input type="checkbox"/> Email <input type="checkbox"/> Primary Caregiver <input type="checkbox"/> DO NOT CONTACT					
Primary Caregiver/Alt Contact Name (If applicable)			Alt Contact Email		Alt Contact Phone

Prescriber Information

Name of Contact Sending Referral	Title	Preferred Contact Method (check one) <input type="checkbox"/> Email <input type="checkbox"/> Phone <input type="checkbox"/> Fax			
Referral Contact Email	Office Phone	Office Fax			
Practice/Facility Name	Prescriber Name/Specialty				
Address	City	State	ZIP		

*** Please include a copy of the front and back of insurance card. ***

Clinical Information – Please include applicable clinical chart notes.

Patient New to Therapy <input type="checkbox"/> Naive/New Start <input type="checkbox"/> Therapy Restart <input type="checkbox"/> Existing Treatment <input type="checkbox"/>					Therapy Start Date
Sample/Starter Provided? <input type="checkbox"/> No <input type="checkbox"/> Yes, Provide Qty:	Date Provided:	Patient Height (cm/in):	Weight (kg/lbs):	Date Obtained:	
Therapies Tried and Failed (please list medications)					
Other/Concomitant Medications (please list)					
Allergies <input type="checkbox"/> NKDA <input type="checkbox"/> Drug Allergies (please list)					
Ship to Address <input type="checkbox"/> Home <input type="checkbox"/> Prescriber's Office <input type="checkbox"/> Other (please list)					
ICD-10 Code	<input type="checkbox"/> M32.8 Other forms of systemic lupus erythematosus <input type="checkbox"/> M32.9 Other forms of systemic lupus erythematosus, unspecified <input type="checkbox"/> M32.10 Systemic lupus erythematosus, organ or system involvement unspecified <input type="checkbox"/> M32.19 Other organ or system involvement in systemic lupus erythematosus <input type="checkbox"/> M05.79 Rheumatoid arthritis with rheumatoid factor of multiple sites w/o organ or systems involvement		<input type="checkbox"/> M05.89 Other rheumatoid arthritis with rheumatoid factor of multiple sites <input type="checkbox"/> M06.89 Other specified rheumatoid arthritis, multiple sites <input type="checkbox"/> M06.9 Rheumatoid arthritis <input type="checkbox"/> Other _____		

Prescription Information – Please Escribe if required by state law.

In order for a brand name product to be dispensed, the prescriber must *handwrite* "Brand Necessary" or "Brand Medically Necessary," or your state-specific required language to prohibit substitutions. This form is not a valid prescription form for writing controlled medications.

MEDICATION	ROUTE	DOSE/STRENGTH	DIRECTIONS	QTY	REFILLS
<input type="checkbox"/> Benlysta (belimumab)	<input type="checkbox"/> IV	<input type="checkbox"/> 10 mg/kg	Starting Dose <input type="checkbox"/> 10 mg/kg IV at weeks 0, 2, 4 and then every ___ weeks Maintenance Dose <input type="checkbox"/> 10 mg/kg IV every ___ weeks	<input type="checkbox"/> 1 month <input type="checkbox"/> 3 months <input type="checkbox"/> _____	<input type="checkbox"/> 1 year <input type="checkbox"/> _____
<input type="checkbox"/> Cimzia (certolizumab)	<input type="checkbox"/> IV	<input type="checkbox"/> 200 mg prefilled syringe <input type="checkbox"/> 200 mg lyophilized powder vial	Starting Dose <input type="checkbox"/> 400 mg (given as two 200 mg subcutaneous injections) at weeks 0, 2, 4 Maintenance Dose <input type="checkbox"/> 200 mg subcutaneous injection every other week <input type="checkbox"/> Other _____	<input type="checkbox"/> 1 month <input type="checkbox"/> 3 months <input type="checkbox"/> _____	<input type="checkbox"/> 1 year <input type="checkbox"/> _____
<input type="checkbox"/> Orencia (abatacept)	<input type="checkbox"/> IV	<input type="checkbox"/> 500 mg Orencia <input type="checkbox"/> 750 mg Orencia <input type="checkbox"/> 1000 mg Orencia	<input type="checkbox"/> Infuse over 30 minutes	<input type="checkbox"/> 1 month <input type="checkbox"/> 3 months <input type="checkbox"/> _____	<input type="checkbox"/> 1 year <input type="checkbox"/> _____
<input type="checkbox"/> Remicade (infliximab) Biosimilars: <input type="checkbox"/> Inflectra <input type="checkbox"/> Remicade	<input type="checkbox"/> IV	Starting Dose <input type="checkbox"/> 5 mg/kg ___mg IV at weeks 0, 2, 6 <input type="checkbox"/> 3 mg/kg ___mg IV at weeks 0, 2, 6 <input type="checkbox"/> Other _____ Maintenance Dose <input type="checkbox"/> ___mg/kg IV every ___ weeks	<input type="checkbox"/> To be infused over a period NOT less than 2 hours	<input type="checkbox"/> 1 month <input type="checkbox"/> 3 months <input type="checkbox"/> _____	<input type="checkbox"/> 1 year <input type="checkbox"/> _____

Prescriber Signature

Date

Supervising Physician Signature (where required by state law)

NPI #

Date

DAW (Dispense as Written)

Date

Brand Necessary (must *handwrite*)

Note: The information contained in this document will become a legal prescription. Prescriber is to comply with his/her state specific pharmacy and medical board guidelines such as e-prescribing, state specific prescription form, fax language, number of prescriptions allowed on a single prescription form, etc. If more than one page is required, make additional copies. Non-compliance with state specific requirements could result in outreach to the prescriber.
Confidentiality Statement: This message is intended only for the individual or entity to which it is addressed. It may contain information which may be proprietary and confidential. It may also contain privileged, confidential information, which is exempt from disclosure under applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA). If you are not the intended recipient, please note that you are strictly prohibited from disseminating or distributing this information (other than to the intended recipient) or copying this information. If you received this communication in error, please notify the sender immediately at the address and telephone number set forth herein and obtain instructions as to proper destruction of the transmitted material.

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Patient Information (Must Be Filled Out to Process Pages Together)

Patient Last Name	Patient First Name	DOB
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MEDICATION	ROUTE	DOSE/STRENGTH	DIRECTIONS	QTY	REFILLS
<input type="checkbox"/> Rituxan (rituximab)	<input type="checkbox"/> IV	<input type="checkbox"/> 1000 mg IV on day 0, day 14 and then repeat the course every ___ weeks <input type="checkbox"/> 375 mg/m ² IV every 4 weeks <input type="checkbox"/> Other _____	<input type="checkbox"/> Infuse as directed	<input type="checkbox"/> 1 month <input type="checkbox"/> 3 months <input type="checkbox"/> _____	<input type="checkbox"/> 1 year <input type="checkbox"/> _____
<input type="checkbox"/> Saphnelo (anifrolumab)	<input type="checkbox"/> IV	<input type="checkbox"/> 300 mg/2 mL Vial	<input type="checkbox"/> To be infused over 30 minutes every 4 weeks IV pump with 0.2 or 0.22 micron filter. Upon completion of the infusion, flush infusion set with 25 mL of 0.9 Sodium Chloride Injection, USP. Prior to initiating therapy, is patient positive for autoantibodies relevant to SLE (e.g., ANA, anti-ds DNA, anti-Sm)? <input type="checkbox"/> Yes <input type="checkbox"/> No Positive ANA or anti-ds DNA test? <input type="checkbox"/> Yes (Date of test: _____) <input type="checkbox"/> No	<input type="checkbox"/> 1 month <input type="checkbox"/> 3 months <input type="checkbox"/> _____	<input type="checkbox"/> 1 year <input type="checkbox"/> _____
<input type="checkbox"/> Simponi Aria (golimumab)	<input type="checkbox"/> IV	Starting dose <input type="checkbox"/> 2 mg/kg ___mg IV at weeks 0, 4 and every 8 weeks <input type="checkbox"/> Other _____ Maintenance Dose <input type="checkbox"/> 2 mg/kg ___mg IV every 8 weeks <input type="checkbox"/> Other _____	<input type="checkbox"/> Infuse diluted solution over a period of 30 minutes	<input type="checkbox"/> 1 month <input type="checkbox"/> 3 months <input type="checkbox"/> _____	<input type="checkbox"/> 1 year <input type="checkbox"/> _____

Vascular Access Method peripheral central other: _____

<input type="checkbox"/> Normal Saline <input type="checkbox"/> D5W	<input type="checkbox"/> IV	<input type="checkbox"/> 3 mL <input type="checkbox"/> 5 mL <input type="checkbox"/> _____	<input type="checkbox"/> Before and after infusion <input type="checkbox"/> _____	<input type="checkbox"/> 1 month <input type="checkbox"/> 3 months <input type="checkbox"/> _____	<input type="checkbox"/> 1 year <input type="checkbox"/> _____
<input type="checkbox"/> Heparin 10 units/mL <input type="checkbox"/> Heparin 100 units/mL	<input type="checkbox"/> IV	<input type="checkbox"/> 3 mL <input type="checkbox"/> 5 mL <input type="checkbox"/> _____	<input type="checkbox"/> After infusion <input type="checkbox"/> _____	<input type="checkbox"/> 1 month <input type="checkbox"/> 3 months <input type="checkbox"/> _____	<input type="checkbox"/> 1 year <input type="checkbox"/> _____
<input type="checkbox"/> Diphenhydramine	<input type="checkbox"/> PO <input type="checkbox"/> IV <input type="checkbox"/> IM	<input type="checkbox"/> 25 mg <input type="checkbox"/> 50 mg <input type="checkbox"/> _____	<input type="checkbox"/> After infusion <input type="checkbox"/> PRN Allergic Reaction: _____ <input type="checkbox"/> _____	<input type="checkbox"/> With each infusion <input type="checkbox"/> _____	<input type="checkbox"/> 1 year <input type="checkbox"/> _____
<input type="checkbox"/> Famotidine	<input type="checkbox"/> IV	<input type="checkbox"/> 20 mg IVP <input type="checkbox"/> 40 mg IVP	<input type="checkbox"/> Pre-Med: _____ <input type="checkbox"/> _____		<input type="checkbox"/> 1 year <input type="checkbox"/> _____
<input type="checkbox"/> Methylprednisolone	<input type="checkbox"/> IV	<input type="checkbox"/> 40 mg IVP <input type="checkbox"/> 125 mg IVP <input type="checkbox"/> _____	<input type="checkbox"/> Pre-Med: _____ <input type="checkbox"/> _____		<input type="checkbox"/> 1 year <input type="checkbox"/> _____
<input type="checkbox"/> Acetaminophen	<input type="checkbox"/> PO	<input type="checkbox"/> 325 mg <input type="checkbox"/> 650 mg <input type="checkbox"/> _____	<input type="checkbox"/> 500 mg <input type="checkbox"/> 1 gm	<input type="checkbox"/> Pre-Med: _____ <input type="checkbox"/> _____	<input type="checkbox"/> With each infusion <input type="checkbox"/> _____
<input type="checkbox"/> Epinephrine	<input type="checkbox"/> IM <input type="checkbox"/> SQ	<input type="checkbox"/> Adult 1:1000, 0.3 mL (>30kg/>66lbs) <input type="checkbox"/> Peds 1:2000, 0.3 mL (15-30kg/33-66lbs)	<input type="checkbox"/> PRN Anaphylaxis <input type="checkbox"/> Repeating Dose: _____	<input type="checkbox"/> Once <input type="checkbox"/> _____	<input type="checkbox"/> 1 year <input type="checkbox"/> _____
<input type="checkbox"/> Other:	<input type="checkbox"/> _____				

Prescriber Signature	Date	Supervising Physician Signature (where required by state law)	NPI #	Date
DAW (Dispense as Written)	Date	Brand Necessary (must handwrite)		

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