

Rheumatology Referral Form

Please complete the following and fax with clinical documentation to: 720.279.7461

Referral Process	
1. PATIENT INFORMATION	2. PHYSICIAN INFORMATION
Name: _____	Physician's name: _____
Address: _____	License #: _____ NPI #: _____
City: _____ State: _____ Zip: _____	DEA #: _____
Home Phone: _____ Other Phone: _____	Address: _____
Email: _____	City: _____ State: _____ Zip: _____
DOB: _____ Social Security #: _____	Office Contact: _____
Gender: <input type="checkbox"/> M <input type="checkbox"/> F Height: _____ Weight: _____	Phone: _____ Fax: _____
3. DIAGNOSIS & OTHER INFORMATION	
<input type="checkbox"/> Rheumatoid Arthritis M05.40 <input type="checkbox"/> Senile Osteoporosis M81.0 <input type="checkbox"/> Psoriatic Arthritis L40.50 <input type="checkbox"/> Ankylosing Spondylitis M08.1 <input type="checkbox"/> Other: _____	
Is patient allergic to latex? <input type="checkbox"/> No <input type="checkbox"/> Yes	
TB Test <input type="checkbox"/> No <input type="checkbox"/> Yes. If yes, results: <input type="checkbox"/> Positive <input type="checkbox"/> Negative	
Hepatitis Test <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative	
4. INSURANCE INFORMATION	
Please submit copies of the front and back of primary and secondary insurance cards with this referral.	
5. PRESCRIPTION INFORMATION	
<input type="checkbox"/> Actemra [®] Infuse: _____ mg, IV over 60 minutes in 50-100 mls 0.9% Sodium Chloride, every _____ weeks. Other: <input type="checkbox"/> Actemra [®] Inject: _____ mg, SC every _____ weeks. May round up to nearest vial size? <input type="checkbox"/> No <input type="checkbox"/> Yes # of Refills _____	
<input type="checkbox"/> Avsola [®] For Rheumatoid Arthritis -- In conjunction with methotrexate: <input type="checkbox"/> 3 mg/kg IV at 0, 2 and 6 weeks, then every 8 weeks <input type="checkbox"/> Alternate dosing: _____ <input type="checkbox"/> For Ankylosing Spondylitis: 5 mg/kg IV at 0, 2 and 6 weeks, then every 6 weeks <input type="checkbox"/> For Psoriatic Arthritis: 5 mg/kg IV at 0, 2 and 6 weeks, then every 8 weeks	
<input type="checkbox"/> Benlysta [®] Infuse 10 mg/kg at 2 week intervals for the first 3 doses and at 4 week intervals thereafter. Dilute dose in 250 mls 0.9% Sodium Chloride and infuse intravenously over 1 hour. # of Refills _____ <input type="checkbox"/> Benlysta [®] Inject 200 mg once weekly by subcutaneous injection. If transition from IV therapy, administer first SC dose 1 to 4 weeks after last IV dose. # of Refills _____	
<input type="checkbox"/> Cimzia [®] Loading dose: Inject 400 mg SC initially and at weeks 2 and 4. # of Refills _____ <input type="checkbox"/> Cimzia [®] Inject 200 mg SC every _____ weeks. # of Refills _____ <input type="checkbox"/> Cimzia [®] Inject 400 mg SC every _____ weeks. # of Refills _____	
<input type="checkbox"/> Enbrel [®] Inject 25 mg SC twice weekly. # of Refills _____ <input type="checkbox"/> Enbrel [®] Inject 50 mg SC once weekly. # of Refills _____ <input type="checkbox"/> Enbrel [®] Inject 50 mg SC twice weekly. # of Refills _____	
<input type="checkbox"/> Forteo [®] 250 mcg/ml in 2.4 ml prefilled pen. Inject 20 mcg SC daily; Use one BD 31g, 5mm needle daily & Forteo Pen # of Refills _____. T-Score: _____ Date _____. Fracture history: Site _____ Date _____	
<input type="checkbox"/> Humira [®] Initial dose: Inject _____ mg SC every _____ weeks. # of Refills _____ <input type="checkbox"/> Humira [®] Subsequent doses: Inject _____ mg SC every _____ weeks. # of Refills _____	

Rheumatology Referral Form, continued

- Inflectra**[®] Administer _____ mg IV over 2 hours in 250 mls 0.9% Sodium Chloride at weeks 0, 2, and 6 followed by every _____ weeks thereafter. # of Refills _____
- Orencia**[®] Administer _____ mg IV over 30 minutes in 100 mls 0.9% Sodium Chloride at weeks 0, 2, and 4 and then every 4 weeks thereafter. # of Refills _____
- Orencia[®] Infuse _____ mg IV loading dose over 30 minutes in 100 mls 0.9% Sodium Chloride
- Orencia[®] Inject _____ mg SC once weekly. # of Refills _____
- Otezla**[®] 30 mg orally twice daily starting on day 6. Initial dosage titration from day 1 or day 5 as follows:
Day 1 - AM: 10 mg; Day 2 - AM: 10 mg and PM: 10 mg; Day 3 - AM: 10 mg and PM: 20 mg;
Day 4 - AM: 20 mg and PM: 20 mg; Day 5 - AM: 20 mg and PM: 30 mg. # of Refills _____
- Prolia**[®] Inject 60 mg/1 ml by subcutaneous injection once every 6 months. # of Refills _____
- Reclast**[®] Infuse 5 mg/100 mls IV over 15-30 minutes every _____ year(s). # of Refills _____
- Remicade**[®] Administer _____ mg IV over 2 hours in 250 mls 0.9% Sodium Chloride at weeks 0, 2, and 6 followed by every _____ weeks thereafter. # of Refills _____
- Renflexis**[®] Administer _____ mg IV over 2 hours in 250 mls 0.9% Sodium Chloride at weeks 0, 2, and 6 followed by every _____ weeks thereafter. # of Refills _____
- Rituxan**[®]
- Administer one course of Rituxan as two 1,000 mg intravenous infusions separated by 2 weeks (repeat course every 24 weeks or less based on clinical evaluation, but not sooner than every 16 weeks. Secure new physician orders prior to each subsequent course).
 - Pre-medicate with:
 - Methylprednisolone 100 mg intravenous 30 minutes prior to each infusion.
 - Other Glucocorticoid: _____
 - Dilute to a final concentration of 1 mg/ml to 4 mg/ml in either 0.9% Sodium Chloride or 5% Dextrose Injection
- Simponi**[®] Inject 50 mg SC once monthly. # of Refills _____
- Simponi Aria**[®] 2 mg/kg IV over 30 minutes at weeks 0 and 4, then every 8 weeks
- Stelara**[®]
- For patients weighing 100kg or less, 45 mg by subcutaneous injection initially and 4 weeks later, followed by 45 mg every 12 weeks. # of Refills _____
 - For patients weighing more than 100kg, 90 mg by subcutaneous injection initially and 4 weeks later, followed by 90 mg every 12 weeks. # of Refills _____
- Taltz**[®]
- For plaque psoriasis: Administer 160 mg (2 mls) by subcutaneous injection at week 0, followed by 80 mg (1 ml) at weeks 2, 4, 6, 8, 10 and 12; then 80 mg every 4 weeks. # of Refills _____
 - For psoriatic arthritis: Administer 160 mg (2 mls) by subcutaneous injection at week 0, followed by 80 mg (1 ml) every 4 weeks. # of Refills _____
- Tymlos**[®] Single patient use pre-filled pen for injection: 3120 mcg/1.56 ml (2000 mcg/ml). Administer 80 mcg/40 mcl by subcutaneous injection once daily. # of Refills _____
- Xeljanz/Xeljanz XR**[®]: Xeljanz 5 mg orally twice daily or Xeljanz XR 11 mg orally once daily. Recommended dosage in patients with moderate to severe renal impairment or moderate hepatic impairment is Xeljanz 5 mg orally once daily.

Is patient taking Methotrexate? No Yes. If yes, Methotrexate _____mg subcutaneously every week
Injection training needed? No Yes

6. FLUSH ORDERS

PIV/midline/PICC: Flush before, after each infusion, and as needed with 3-20 ml NS, followed by Heparin 2-5 ml if indicated

- Heparin 10 unit/ml Heparin 100 unit/ml

Port: Flush before, after each infusion, and as needed with 5-20 ml NS, followed by:

- Heparin 100 unit/ml 5 ml for adults Heparin 10 unit/ml 5 ml for pediatrics

Rheumatology Referral Form, continued

7. ANAPHYLAXIS ORDERS

Adults: For mild reaction-administer diphenhydramine 50mg IVP/PO x 1.

For severe reactions-administer epinephrine 0.3mg SubQ/IM x 1. May repeat x1 if needed. Contact 911 and monitor vital signs.

Pediatrics: administer by age: For mild reaction (rash/hives) give diphenhydramine

Age 1-5: 12.5mg IV/PO x1

Age 6-11: 25mg IV/PO x1

Age 12+: 50mg IV/PO x1

For severe reaction (airway closure) administer epinephrine. 0.01mg/kg/dose (max 0.3mg) SubQ/IM x 1.

If needed, repeat a second dose after 5-10 minutes for a maximum of two doses. Contact 911 and monitor vital signs.

Other: _____

8. Dispense as written Substitution Permitted

PHYSICIAN'S SIGNATURE (required): _____ **Date:** _____

www.veroshealth.com

Prescription is valid for one year unless otherwise indicated.

The prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.

© Veros Health. All rights reserved. 01.22