VEROS HEALTH
Excellence in Complex Care

Rheumatology Referral Form

Please complete the following and fax with clinical documentation to: 720.870.2414

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: ☐ M ☐ F Height: _____ Weight: _____	Phone: _____ Fax: _____

3. DIAGNOSIS & OTHER INFORMATION

☐ Rheumatoid Arthritis M05.40 ☐ Senile Osteoporosis M81.0 ☐ Psoriatic Arthritis L40.50
☐ Ankylosing Spondylitis M08.1 ☐ Other: _____

Is patient allergic to latex? ☐ No ☐ Yes
TB Test ☐ No ☐ Yes. If yes, results: ☐Positive ☐Negative
Hepatitis Test ☐No ☐Yes | If yes, result: ☐Positive ☐Negative

4. INSURANCE INFORMATION

Please submit copies of the front and back of primary and secondary insurance cards with this referral.

5. PRESCRIPTION INFORMATION

☐ **Actemra®** Infuse: _____ mg, IV over 60 minutes in 50-100 mls 0.9% Sodium Chloride, every _____ weeks. Other:
☐ Actemra® Inject: _____ mg, SC every _____ weeks.
May round up to nearest vial size? ☐ No ☐ Yes # of Refills _____

☐ **Avsola®**
For Rheumatoid Arthritis -- In conjunction with methotrexate:
☐ 3 mg/kg IV at 0, 2 and 6 weeks, then every 8 weeks
☐ Alternate dosing: _____
☐ For Ankylosing Spondylitis: 5 mg/kg IV at 0, 2 and 6 weeks, then every 6 weeks
☐ For Psoriatic Arthritis: 5 mg/kg IV at 0, 2 and 6 weeks, then every 8 weeks

☐ **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 _____
☐ 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 _____

☐ **Cimzia®** Loading dose: Inject 400 mg SC initially and at weeks 2 and 4. # of Refills _____
☐ Cimzia® Inject 200 mg SC every _____ weeks. # of Refills _____
☐ Cimzia® Inject 400 mg SC every _____ weeks. # of Refills _____

☐ **Enbrel®** Inject 25 mg SC twice weekly. # of Refills _____
☐ Enbrel® Inject 50 mg SC once weekly. # of Refills _____
☐ Enbrel® Inject 50 mg SC twice weekly. # of Refills _____

☐ **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 _____

☐ **Humira®** Initial dose: Inject _____ mg SC every _____ weeks. # of Refills _____
☐ Humira® Subsequent doses: Inject _____ mg SC every _____ weeks. # of Refills _____

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☐ **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

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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: ____