Rheumatoid Referral Form

Please fax completed referral form to ivira:
(302) 499-8729

Please contact office for questions:
(302) 499-8727

PATIENT DEMOGRAPHICS:

PATIENT NAME:	PREFERRED CONTACT #:
DATE OF REFERRAL:	SECONDARY CONTACT #:
SOCIAL SECURITY NUMBER:	ADDRESS:
DATE OF BIRTH:	CITY, STATE, ZIP:

PRIMARY DIAGNOSIS: PLEASE PROVIDE ICD-IO CODE

- ☐ M06.9 - Rheumatoid arthritis, unscpecified
- ☐ M08.00 Unspecified juvenile rheumatoid arthritis, unspecified
- ☐ M08.3 - Juvenile rheumatoid polyarthritis (seronegative)
- ☐ M45.9 - Ankylosing spondylitis of unspecified site in spine
- ☐ L40.59 - Other psoriatic Anthropathy
- ☐ Other: __________-________________________

PRIOR THERAPY: PLEASE PROVIDE MEDICATION HISTORY

PRIOR THERAPY (if any):	APPROX START DATE:	APPROX. END DATE:	REASON FOR DISCONTINUATION:

PATIENT INFORMATION:

ALLERGIES: ☐ NKDA

HEIGHT: ____ Ft ____ In WEIGHT: ____Lb or ____ Kg

GENDER: ☐ F ☐ M

I hereby authorize Accredo to contact my prescribing provider to coordinate the delivery, receipt and storage of my prescription medication for the sole purpose of administration by my prescribing provider at my next scheduled appointment. Signature serves as the Patient Ship Authorization.

PATIENT SIGNATURE:

REQUIRED DOCUMENTATION: PLEASE PROVIDE A COPY OF THE FOLLOWING DOCUMENTS

- ☐ 1. INSURANCE CARD (Front & Back)
- ☐ 2. PATIENT DEMOGRAPHICS
- ☐ 3. MOST RECENT LABS
- ☐ 4. H & P
- ☐ 5. NEGATIVE TB TEST RESULTS
- ☐ 6. NEGATIVE HEPATITIS B TEST RESULTS

TESTING RESULTS: If prescribing, Cimzia, Humira, Remicade, Stelara

ACTIVE TB? ☐ YES ☐ NO SCREENING DATE: ____________

ACTIVE HEP B? ☐ YES ☐ NO SCREENING DATE: ____________

MEDICATION WASTE:

Authorized to round up to nearest vial size?

☐ YES ☐ NO

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

☐ ADMINISTER ACUTE INFUSION AND ANAPHYLAXIS MEDICATIONS PER GREENHILL INFUSION POLICY AND PROCEDURE

☐ OTHER: (please fax other reaction orders if checking this box)

PRN & PREMEDICATIONS:

MEDICATIONS	30 minutes prior every infusion	PRN
Acetaminophen ____ mg PO	☐	☐ PRN every ____ hours for mild or moderate infusion reaction.
Diphenhydramine ____ mg PO	☐	☐ PRN every ____ hours for mild or moderate infusion reaction.
Diphenhydramine ____ mg diluted in 10mL 0.9% NaCl slow IV push over 2-3 minutes.	☐	☐ PRN every ____ hours for mild or moderate infusion reaction.
Methylprednisolone ____ mg IV push over 5 minutes.	☐	
Methylprednisolone 100mg IV	☐	

PRESCRIBER INFORMATION:

PHYSICIAN NAME:	PHONE:
OFFICE CONTACT:	FAX:
ADDRESS:	LICENSE #:
CITY, STATE, ZIP:	NPI:

PHYSICIAN SIGNATURE: DATE:

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MEDICATION SELECTION:

Medication	Dose
ACTEMRA® tocilizumab	**INDUCTION DOSE:** ☐ 4 MG/KG IV EVERY 4 WEEKS **MAINTENANCE DOSE:** ☐ 8 MG/KG IV EVERY 4 WEEKS **OTHER:** ☐ ________________________________ REFILLS:______
ACTEMRA® tocilizumab INJECTION	**PT <100 KG:** ☐ INJECT 162 MG SC EVERY OTHER WEEK, FOLLOWED BY AN INCREASE TO EVERY WEEK BASED ON CLINICAL RESPONSE **PT > 100 KG:** ☐ INJECT 162 MG SC EVERY WEEK REFILLS:______
Benlysta® (belimumab) For Intravenous Injection 120 mg/vial	**INDUCTION DOSE:** ☐ 10 MG/KG/DOSE IV INFUSED OVER 1 HOUR EVERY 2 WEEKS FOR 3 DOSES **MAINTENANCE DOSE:** ☐ 10 MG/KG IV EVERY 4 WEEKS REFILLS:______
Benlysta® (belimumab) INJECTION	**MAINTENANCE DOSE:** ☐ INJECT 200 MG SC ONCE WEEKLY REFILLS:______
cimzia (certolizumab pegol)	**INDUCTION DOSE:** ☐ 400 MG SC on WEEKS 0, 2, & 4 **MAINTENANCE DOSE:** ☐ 400 MG SC EVERY 4 WEEKS ☐ 200 MG SC EVERY 2 WEEKS REFILLS:______
Cosentyx® (secukinumab)	*Psoriatic Arthritis w/ Coexistent Moderate to Severe Plaque Psoriasis* **LOADING DOSE:** ☐ INJECT 300 MG SC on WEEKS 0,1,2,3 & 4 **MAINTENANCE DOSE:** ☐ INJECT 300 MG SC EVERY 4 WEEKS REFILLS:______ *Other Psoriatic Arthritis or Ankylosing Spondylitis* **LOADING DOSE:** ☐ INJECT 150 MG SC on WEEKS 0, 1, 2, 3, & 4, THEN EVERY 4 WEEKS **NO LOADING DOSE:** ☐ INJECT 150 MG EVERY 4 WEEKS REFILLS:______
Enbrel® etanercept	☐ INJECT 25 MG SC TWO TIMES A WEEK ☐ INJECT 50 MG SC ONCE WEEKLY ☐ OTHER: _______ MG (0.8 MG/KG X _____KG) SC EVERY WEEK REFILLS:______
HUMIRA adalimumab	☐ INJECT 40 MG SC EVERY WEEK ☐ INJECT 40 MG SC EVERY TWO WEEKS ☐ OTHER: ________________________________ REFILLS:______
Inflectra® infliximab	**INDUCTION DOSE:** ☐ 5 MG/KG IV on WEEKS 0, 2, & 6 **MAINTENANCE DOSE:** ☐ 5 MG/KG OR ☐ 10 MG/KG IV EVERY 8 WEEKS **ALTERNATIVE DOSE:** ☐ _____ MG/KG IV EVERY ____ WEEKS REFILLS:______
KEVZARA® (sarilumab)	☐ INJECT 200 MG SC ONCE EVERY TWO WEEKS ☐ INJECT 150 MG SC ONCE EVERY TWO WEEKS REFILLS:______
KRYSTEXXA® pegloticase	☐ INFUSE 8 MG IV ONCE EVERY TWO WEEKS REFILLS:______
olumiant® (baricitinib) tablets 2 mg	☐ TAKE 2 MG BY MOUTH DAILY ☐ OTHER: ________________________________ REFILLS:______

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MEDICATION SELECTION:

Medication	Dosing
ORENCIA® (abatacept)	**PATIENT WEIGHT:** ☐ <60KG = 500 MG ☐ 60-100 KG = 750 MG ☐ >100 KG = 1000 MG **MAINTENANCE DOSE:** ☐ INFUSE _______ MG IV on WEEKS 0, 2, & 4, THEN EVERY 4 WEEKS **OTHER:** ☐ ____________________________________ REFILLS:______
ORENCIA® (abatacept)	☐ INJECT 125 MG SC EVERY WEEK ☐ INJECT 87.5 MG SC EVERY WEEK ☐ INJECT 50MG SC EVERY WEEK REFILLS:______
Otezla® (apremilast) 30mg tablets	**INDUCTION DOSE:** ☐ TITRATION PACK **MAINTENANCE DOSE:** ☐ TAKE 30 MG BY MOUTH TWICE DAILY REFILLS:______
Remicade® INFLIXIMAB	**INDUCTION DOSE:** ☐ 5 MG/KG IV on WEEKS 0, 2, & 6 **MAINTENANCE DOSE:** ☐ 5 MG/KG OR ☐ 10 MG/KG IV **EVERY 6 WEEKS** **MAINTENANCE DOSE:** ☐ 5 MG/KG OR ☐ 10 MG/KG IV **EVERY 8 WEEKS** **ALTERNATIVE DOSE:** ☐ _____ MG/KG IV EVERY ____ WEEKS REFILLS:______
RINVOQ™ upadacitinib 15mg tablets	☐ TAKE 15 MG BY MOUTH ONCE DAILY REFILLS:______
Simponi® golimumab	☐ INJECT 50 MG SC EVERY 4 WEEKS REFILLS:______
Simponi® ARIA™ golimumab for infusion	☐ INJECT 2 MG/KG IV on WEEKS 0, 4, & EVERY 8 WEEKS THEREAFTER REFILLS:______
Stelara® (ustekinumab)	**LOADING DOSE:** ☐ 45 MG SC THEN 45 MG SC 4 WEEKS LATER or ☐ 90 MG SC THEN 90 MG SC 4 WEEKS LATER **MAINTENANCE DOSE:** ☐ 45 MG SC EVERY 12 WEEKS or ☐ 90 MG SC EVERY 12 WEEKS REFILLS:______
taltz® (ixekizumab) injection	**INDUCTION DOSE:** ☐ 160 MG AT WEEKS 0, FOLLOWED BY 80 MG AT WEEKS 2, 4, 6, 8, 10, & 12 **MAINTENANCE DOSE:** ☐ 80 MG SC EVERY 4 WEEKS REFILLS:______
XELJANZ® [tofacitinib]	**IR:** ☐ 5 MG PO BID x #60 **XR:** ☐ 22 MG PO DAILY ☐ 11 MG PO DAILY x #30 REFILLS:______

MEDICATION SELECTION: (BONE AGENTS)

Medication	Dosing
FORTÉO™ teriparatide (rDNA origin) injection	☐ INJECT 20 MCG SC, AS DIRECTED, DAILY REFILLS:______
prolia® denosumab	☐ INJECT 60 MG SC ONCE EVERY 6 MONTHS REFILLS:______
TYMLOS® (abaloparatide) injection	☐ INJECT 80 MG SC ONCE DAILY IN PERIUMBILICAL REGION REFILLS:______