ivira infusions

Rheumatology Referral Form

Please fax completed referral form to ivira:
(302) 486-3400
Please contact office for questions:
(302) 356-0506

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	FIRST DOSE: ☐ Y ☐ N
	DATE OF LAST INFUSION:
	NEXT DOSE DUE BY:
HEIGHT: ____ Ft ____ In WEIGHT: ____ Lb or ____ Kg	ACCESS/LINE TYPE: ☐ PIV ☐ PORT ☐ PICC ☐ MIDLINE
GENDER: ☐ F ☐ M	OTHER:

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:

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:_____

MEDICATION SELECTION:

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 x #30
☐ 11 MG PO DAILY REFILLS:_____

MEDICATION SELECTION: (BONE AGENTS)

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:_____

Clear All Print