# Rheumatology Referral Form

**Fax completed form to: 833-908-1122**

amerita specialty infusion services

NEXTRON Infusion Services an amerita company

## PATIENT INFORMATION

| | | |
|---|---|---|
| Patient Name: | Date of Birth: | Referral Date: |
| Address: | City/State/Zip: | |
| Home Phone: | Cell Phone: | Work Phone: |
| Secondary Contact: | Height: Weight: | ☐ Male ☐ Female |
| Patient Diagnosis & ICD-10: | | |
| Allergies: | | |

## PROVIDER INFORMATION

| | | |
|---|---|---|
| Physician Name: | Lic.#: | DEA #: |
| Practice Name: | | NPI#: |
| Address: | | City/State/Zip: |
| Office Contact: | Phone: | Fax: |
| Supervisory Physician (if applicable): | | |

## PLEASE ATTACH

- ☐ Patient demographics & front/back copy of all insurance cards (prescription & medical)
- ☐ Recent office visit notes, history & physical, lab & pertinent procedure results
- ☐ Current medication list & list of prior medications tried and failed (with dates)
- ☐ HBV lab results within last 12 months *(Infliximabs only, Orencia & Actemra only)*
- ☐ TB lab results within last 12 months *(except for Prolia/Evenity)*
- ☐ Absolute neutrophil count (ANC), platelet count, ALT and AST lab results *(Actemra only)*
- ☐ Letter of medical necessity if drug dosing or indication is outside of FDA guidelines

## NURSING & LAB ORDERS

**Nurse Orders:** Nurse to provide assessment, teaching, lab draws, medication administration and vascular access device insertion and/or management per physician orders.

**Flush Orders:** *NaCl 0.9%* - 5-10mL flush pre and post infusion and as needed *Heparin* - ☐ 10units/mL ***---OR---*** ☐100units/mL - 3-5mL flush after post-infusion NS flush if indicated to maintain line

**Lab Orders:** **Lab Date & Frequency:**

## PRESCRIPTION ORDERS

**Anaphylaxis Kit:** (Check all that apply)
☐ Epinephrine 0.3mg IM as needed ☐ Solu-cortef 250mg-500mg IV infusion as needed ☐ Solu-Medrol 60mg - 125mg IV infusion as needed
☐ Diphenhydramine _____ mg IV infusion as needed ☐ NS Hydration 500 ml IV infusion over 30 minutes as needed ☐ Other

**Pre-Medications:** (Check all that apply)
☐ Acetaminophen _____mg PO _____ minutes prior to infusion ☐ Solu-Medrol _____mg IV infusion _____minutes prior to infusion
☐ Diphenhydramine _____ mg ☐ PO ***---OR---*** ☐ IV infusion _____minutes prior to infusion ☐ Other

**Supply Orders:** All supplies for vascular access line care, drug administration kit(s), pump, and IV pole will be provided as necessary

| PRODUCT | PRESCRIPTION INFORMATION | REFILLS |
|---|---|---|
| | Is this a first dose? ☐ Yes ☐ No If No, when was last dose given?_____ When is patient due for next dose?_____ | |
| ☐ ACTEMRA | ☐ **Induction**: 4mg/kg IV infusion via ☐gravity- ***--OR---*** ☐pump over at least 1 hour every ____weeks | NONE |
| | ☐ **Maintenance**: IV infusion of ☐ 4mg/kg ☐ 6mg/kg ☐8mg/kg ☐ 10mg/kg ☐12mg/kg ☐ _____mg/kg (max of 800mg) via ☐gravity- ***--OR---*** ☐pump over at least 1 hour Every ☐ week (patients >100kg or based on clinical response) ☐ 2 weeks (patients <100kg) ☐ Other:_____ ☐ Round up to nearest whole vial (must choose for Medicaid patients) ☐ Give exact dose | _____ |
| ☐ EVENITY | 210mg SC injection monthly (recommended total of 12 doses) | _____ |
| ☐ ILARIS | **For Stills Disease including Adult Onset Stills Disease and Systemic Juvenile Idiopathic Arthritis** ☐ 4mg/kg SC injection (max of 300mg) for patients ≥ 7.5kg every 4 weeks<br>**For Cryopyrin-Associated Periodic Syndromes (CAPS)** ☐ 150mg SC injection for patients >40kg every 8 weeks ☐ 2mg/kg ☐ 3mg/kg SC injection for patients 15kg-40kg every 8 weeks | _____ |
| ☐ INFLIXIMAB ☐Avsola ☐Inflectra ☐Remicade ☐Renflexis | ☐ **Induction**: ☐3mg/kg ☐ 5mg/kg ☐ 7.5mg/kg ☐ 10mg/kg or ☐ ____ mg IV infusion via ☐ gravity- ***--OR---*** ☐ pump over at least 2 hours at weeks 0, 2, and 6 | NONE |
| | ☐ **Maintenance**: ☐3mg/kg ☐ 5mg/kg ☐ 7.5mg/kg ☐ 10mg/kg ☐ ____ mg IV infusion via ☐ gravity ***---OR---*** ☐ pump over at least 2 hours every _____ weeks *(Note: Round to nearest 100mg for Medicaid patients)* If Remicade infusion tolerated, adjust infusion time according to manufacturer package insert. | _____ |
| ☐ ORENCIA | ☐ **Induction:** _____mg IV infusion via ☐gravity- ***--OR---*** ☐pump over at least 30 minutes at week 0,2 and 4 | NONE |
| | ☐ **Maintenance:** _____mg IV infusion via ☐gravity ***---OR---*** ☐pump over at least 30 minutes every _____weeks ☐ 10kg to <25kg = 50mg SC injection weekly ☐ 25kg to <50kg 87.5 mg SC injection weekly ☐ 50kg or more 125mg SC injection weekly | _____ |
| ☐ PROLIA | 60mg SC injection every 6 months | _____ |
| ☐ STELARA | **Psoriasis Adult Subcutaneous** ☐ For patients ≤ 100 kg, 45 mg SC injection initially and 4 weeks later, followed by 45 mg every 12 weeks ☐ For patients > 100 kg, 90 mg SC injection initially and 4 weeks later, followed by 90 mg every 12 weeks **Psoriatic Arthritis Adult** ☐ 45 mg SC injection initially and 4 weeks later, followed by 45 mg SC injection every 12 weeks ☐ For patients with co-existent moderate-to-severe plaque psoriasis weighing >100 kg, 90 mg SC injection initially and 4 weeks later, then every 12 weeks | _____ |
| ☐ KRYSTEXXA | ***For KRYSTEXXA, please refer to KRYSTEXXA Order Form*** ☐ RITUXIMAB ***For RITUXIMAB, please refer to RITUXIMAB Order Form*** | |
| ☐ OTHER | | _____ |

***By signing this form and utilizing our services, you are authorizing Amerita to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.***

**Prescriber's Signature** **Print Name** **Date**
**Dispense as Written**

**Prescriber's Signature** **Print Name** **Date**
**Substitution Permitted**


*AME NEX Rheumatology Refer 10-23*

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