FAX ORDER TO 561-516-6626

Rheumatology Referral Form

Please Attach Copy of Insurance Cards (Front & Back)

Last Name:	First Name:	DOB:	Practice:
Address:			Address:
City:	State:	Zip: Sex: ◯M ◯F	City: State: Zip:
Phone:	SSN#		Prescriber Name:

Insurance Information

		Prescriber NPI:
Insurance Plan:	Insurance Plan:	Nurse/Key Contact:
Policy #	Policy #	Phone:
Plan I.D. #	Plan I.D. #	Fax: Email:

Diagnosis and Clinical Information

Please Attach Clinical/Progress Notes, Labs, Test, Supporting Primary Diagnosis

☐ Rheumatoid Arthritis ☐ Lupus Erythematosus
☐ Ankylosing Spondylitis ☐ Arthritic Psoriasis
☐ Gout
☐ Other: ______________________

ICD-10:______________

Currently received and/or prior filed therapies: ______________

____

Length of Treatment: ______________________

Reason for Discontinuation: ______________________

TB/PPD Test: ☐ Positive ☐ Negative Date ____________

Hep. B ☐ Positive ☐ Negative Date ____________

Allergies: ______________________

____

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☐ NKDA

Height ________ Weight ________

Site of Care: ☐ Home ☐ AIC ☐ Other____________

Prescription Information

Medication	Dose/Strength	Directions
☐ Remicade (infliximab)	☐ 100mg vial	☐ INITIAL: Infuse _______ mg/kg IV over 2-3 hours at week 0, 2, 6 then every 8 weeks thereafter ☐ MAINTENANCE: Infuse _____ mg/kg IV over 2-3 hours every ____ weeks
☐ Stelara (ustekinumab)	☐ 45mg vial	☐ INITIAL: 45mg SUBQ initially, 4 weeks later, followed by 45mg every 12 weeks ☐ MAINTENANCE: 45mg SUBQ every 12 weeks ☐ INITIAL: 90mg SUBQ initially, 4 weeks later, followed by 90mg every 12 weeks ☐ MAINTENANCE: 90mg SUBQ every 12 weeks
☐ Simponi (golimumab) ARIA	☐ 50mg vial	☐ INITIAL: 2mg/kg IV at weeks 0, 4, and then every 8 weeks ☐ MAINTENANCE: 2mg/kg IV every 8 weeks
☐ Cimzia (certolizumab)	☐ 200mg vial	☐ INITIAL: 400mg SUBQ at weeks 0, 2, and 4 weeks ☐ MAINTENANCE: 200 mg SUBQ every 2 weeks ☐ MAINTENANCE: 400 mg SUBQ every 4 weeks
☐ Orencia (abatacept)	☐ 250mg vial	☐ INITIAL: ____ mg IV Frequency ☐ Every 4 weeks **OR** ☐ 0, 2, 4 weeks and every 4 weeks thereafter
☐ Krystexxa (pegloticase)	☐ 8mg	Infuse 8mg IV over 2 hours every 2 weeks

Pre-Medication & Other Medications
* Infusion supplies as per protocol
* Anaphylaxis Kit as per protocol

☐ Acetaminophen mg PO prior to infusion
☐ Diphenhydramine mg ☐ PO ☐ IV
☐ Methylprednisolone_______mg IV over _____ min.
☐ Other

Flush Protocol
* NaCl 0.9% 10ml
* Before & After Infusion

I authorize Infuse One and its representatives to initiate any insurance prior authorization process that is required for this prescription and for any future refills of the same prescription for the patient listed above which I order. I understand that I can revoke this designation at any time by providing written notice to Infuse One

Physician Signature: ______________________

Date: ______________________

PRESCRIBER MUST MANUALLY SIGN - STAMP SIGNATURE, SIGNATURE BY OTHER PERSONNEL AND COMPUTER-GENERATED SIGNATURES WILL NOT BE ACCEPTED

The attached document(s) contain confidential information which may be considered to be Protected Health Information and therefore required to be maintained as private and secure under HIPAA. The documents may also contain information which is otherwise considered to be privileged under state and federal laws. This communication is for the intended recipient only. If you are not the intended recipient, or a person responsible for delivering this communication to the intended recipient, you are prohibited from viewing, copying and/or distributing the information contained herein. Unlawful disclosure of the information attached may subject you to monetary penalties and sanctions. If you have received this communication in error, you should notify the sender immediately and thereafter permanently destroy all copies of this document in its entirety.

This form is not considered an order or prescription for medical services and/or supplies unless and until it is formally authorized by a healthcare provider in compliance with applicable laws and regulations.