



Please refer to website www.infuseone.com for location specific fax numbers

### Rheumatology Referral Form

**\*\*Please Attach Copy of Insurance Cards (Front & Back)\*\***

Last Name:	First Name:	DOB:	Practice:
Address:			Address:
City:	State:	Zip:	Sex: <input type="radio"/> M <input type="radio"/> F
City:	State:	Zip:	
Phone:	SSN#	Prescriber Name:	
<b>Insurance Information</b>			
Insurance Plan:	Insurance Plan:	Prescriber NPI:	
Policy #	Policy #	Nurse/Key Contact:	
Plan I.D. #	Plan I.D. #	Phone:	
		Fax:	Email:

### Diagnosis and Clinical Information

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

<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Lupus Erythematosus	TB/PPD Test: <input type="checkbox"/> Positive <input type="checkbox"/> Negative	Date _____
<input type="checkbox"/> Ankylosing Spondylitis	<input type="checkbox"/> Arthritic Psoriasis	Hep. B <input type="checkbox"/> Positive <input type="checkbox"/> Negative	Date _____
<input type="checkbox"/> Gout		Allergies: _____	
<input type="checkbox"/> Other: _____			
ICD-10: _____			
Currently received and/or prior filed therapies: _____	<input type="checkbox"/> NKDA	Height _____ Weight _____	
Length of Treatment: _____		Site of Care: <input type="checkbox"/> Home <input type="checkbox"/> AIC <input type="checkbox"/> Other _____	
Reason for Discontinuation: _____			

### Prescription Information

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

#### Pre-Medication & Other Medications

- \* Infusion supplies as per protocol
- \* Anaphylaxis Kit as per protocol

<input type="checkbox"/> Acetaminophen	mg PO prior to infusion
<input type="checkbox"/> Diphenhydramine	mg <input type="checkbox"/> PO <input type="checkbox"/> IV
<input type="checkbox"/> Methylprednisolone _____ mg	IV over _____ min.
<input type="checkbox"/> 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.