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

INFUSE ONE

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
☐ Ankylosing Spondylitis
☐ Gout
☐ Other: _____
ICD-10: _____

☐ Lupus Erythematosus
☐ Arthritic Psoriasis

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: _____

☐ 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
☐ Diphenhydramine
☐ Methylprednisolone_____mg
☐ Other

mg PO prior to infusion
mg ☐ PO ☐ IV
IV over _____ min.

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