

RHEUMATOLOGY INFUSION REFERRAL FORM



PATIENT INFORMATION

Last Name	First Name	DOB
Gender	Last 4 SSN	Primary Language
Address		
City	State	ZIP
Email		
Home Phone	Work Phone	Cell Phone
Primary Contact Method (check one)	<input type="checkbox"/> Cell Phone <input type="checkbox"/> Home Phone <input type="checkbox"/> Work Phone <input type="checkbox"/> Text <input type="checkbox"/> Email <input type="checkbox"/> Primary Caregiver <input type="checkbox"/> DO NOT CONTACT	
Primary Caregiver/Alt Contact Name (if applicable)		
Caregiver/Alt Contact Email	Caregiver/Alt Contact Phone	

PRESCRIBER INFORMATION

Name of Contact Sending Referral	Title	
Preferred Contact Method (check one)	<input type="checkbox"/> Email <input type="checkbox"/> Phone <input type="checkbox"/> Fax	Referral Contact Email
Office Phone	Office Fax	
Practice / Facility Name		
Address		
City	State	ZIP
Prescriber Name / Specialty		
Prescriber State License #	DEA #	
NPI #	Medicaid UPIN #	

INSURANCE INFORMATION

Insurance Provider	Plan ID #	
BIN#:	PCN#:	RX Group#:
Insured's Name	Relationship to Patient	

Eligible for Medicare (check one)	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, list Medicare #
Prescription Card (check one)	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, list carrier

Please include a copy of the front and back of insurance card.

CLINICAL INFORMATION

Prescription Type	<input type="checkbox"/> Naïve/New Start <input type="checkbox"/> Therapy Restart <input type="checkbox"/> Existing Treatment	Therapy Start Date
Sample/Starter Product Provided?	If yes, Provide Qty	Date Sample Provided
<input type="checkbox"/> Yes <input type="checkbox"/> No		
Allergies <input type="checkbox"/> NKDA <input type="checkbox"/> Drug Allergies (please list)		
Therapies Tried and Failed (please list medications)		
Concurrent Medications		

Patient Height (cm/in)	Patient Weight (kg/lbs)	Date Obtained
Ship to Address <input type="checkbox"/> Home <input type="checkbox"/> Prescriber's Office <input type="checkbox"/> Other (please list)		
ICD-10 Codes	<input type="checkbox"/> M32.8 Other forms of systemic lupus erythematosus <input type="checkbox"/> M32.9 Other forms of systemic lupus erythematosus, unspecified <input type="checkbox"/> M32.10 Systemic lupus erythematosus, organ or system involvement unspecified <input type="checkbox"/> M32.19 Other organ or system involvement in systemic lupus erythematosus <input type="checkbox"/> M05.79 Rheumatoid arthritis with rheumatoid factor of multiple sites w/o organ or systems involvement <input type="checkbox"/> M05.89 Other rheumatoid arthritis with rheumatoid factor of multiple sites <input type="checkbox"/> M06.89 Other specified rheumatoid arthritis, multiple sites <input type="checkbox"/> M06.9 Rheumatoid Arthritis <input type="checkbox"/> Other _____	

We accept Escribe and fax prescriptions.

Phone 855.896.9254 | Fax 855.370.0086

PRESCRIPTIONS

Patient Last Name	Patient First Name	DOB
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PRESCRIPTION INFORMATION

MEDICATION	ROUTE	DOSE/STRENGTH	DIRECTIONS	QTY	REFILLS
<input type="checkbox"/> Vascular Access Method <input type="checkbox"/> peripheral <input type="checkbox"/> central <input type="checkbox"/> other: _____					
<input type="checkbox"/> Normal Saline <input type="checkbox"/> D5W	<input type="checkbox"/> IV	<input type="checkbox"/> 3 mL <input type="checkbox"/> 5 mL <input type="checkbox"/> _____	<input type="checkbox"/> Before and after infusion <input type="checkbox"/> _____	<input type="checkbox"/> 1 month <input type="checkbox"/> 3 months <input type="checkbox"/> _____	<input type="checkbox"/> 1 year <input type="checkbox"/> _____
<input type="checkbox"/> Heparin 10 units/mL <input type="checkbox"/> Heparin 100 units/mL	<input type="checkbox"/> IV	<input type="checkbox"/> 3 mL <input type="checkbox"/> 5 mL <input type="checkbox"/> _____	<input type="checkbox"/> After infusion <input type="checkbox"/> _____	<input type="checkbox"/> 1 month <input type="checkbox"/> 3 months <input type="checkbox"/> _____	<input type="checkbox"/> 1 year <input type="checkbox"/> _____
<input type="checkbox"/> Diphenhydramine	<input type="checkbox"/> PO <input type="checkbox"/> IV <input type="checkbox"/> IM	<input type="checkbox"/> 25 mg <input type="checkbox"/> 50 mg <input type="checkbox"/> _____	<input type="checkbox"/> After infusion <input type="checkbox"/> PRN Allergic Reaction: _____ <input type="checkbox"/> _____	<input type="checkbox"/> With each infusion <input type="checkbox"/> _____	<input type="checkbox"/> 1 year <input type="checkbox"/> _____
<input type="checkbox"/> Famotidine	<input type="checkbox"/> IV	<input type="checkbox"/> 20 mg IVP <input type="checkbox"/> 40 mg IVP	<input type="checkbox"/> Pre-Med: _____ <input type="checkbox"/> _____		<input type="checkbox"/> 1 year <input type="checkbox"/> _____
<input type="checkbox"/> Methylprednisolone	<input type="checkbox"/> IV	<input type="checkbox"/> 40 mg IVP <input type="checkbox"/> 125 mg IVP <input type="checkbox"/> _____	<input type="checkbox"/> Pre-Med: _____ <input type="checkbox"/> _____		<input type="checkbox"/> 1 year <input type="checkbox"/> _____
<input type="checkbox"/> Acetaminophen	<input type="checkbox"/> PO	<input type="checkbox"/> 325 mg <input type="checkbox"/> 500 mg <input type="checkbox"/> 650 mg <input type="checkbox"/> 1 gm <input type="checkbox"/> _____	<input type="checkbox"/> Pre-Med: _____ <input type="checkbox"/> _____	<input type="checkbox"/> With each infusion <input type="checkbox"/> _____	<input type="checkbox"/> 1 year <input type="checkbox"/> _____
<input type="checkbox"/> Epinephrine	<input type="checkbox"/> IM <input type="checkbox"/> SQ	<input type="checkbox"/> Adult 1:1000, 0.3 mL (>30kg/>66lbs) <input type="checkbox"/> Peds 1:2000, 0.3 mL (15-30kg/33-66lbs)	<input type="checkbox"/> PRN Anaphylaxis <input type="checkbox"/> Repeating Dose: _____	<input type="checkbox"/> Once <input type="checkbox"/> _____	<input type="checkbox"/> 1 year <input type="checkbox"/> _____
<input type="checkbox"/> Other:	<input type="checkbox"/> _____				

Total RXs _____

Lab Orders _____
 Skilled nursing visits as needed to establish venous access administer medication and assess general status and response to therapy. Dispense 1 month of drug, flushes, needles, syringes, ancillary supplies and medical equipment necessary to establish access and administer medication. Prescription to include all necessary ancillary supplies (needle, syringes, etc). If shipped to physician's office, physician accepts on behalf of patient for administration in office.

Patient Support Programs: Please have patient sign and date to enroll in pharmaceutical company assisted support program.

Patient Signature	Date	Account Manager
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Prescriber Authorization (No stamps. Signature and date must be completed in prescriber's handwriting.)

Prescriber Signature	Date
Supervising Physician Signature (Dispense as Written)	Date

**The information contained in this document will become a legal prescription. Follow all state Medical Board guidelines when completing, inclusive of guidelines that pertain to the number of prescriptions allowed on a single prescription form. If more than one page is required, make additional copies. Use state board mandated language for dispensing brand name medications or generic substitution and follow physician signature requirements.

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