

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 | | | |
| 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"/> Kystexxa (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 Vital Care Infusion Services LLC 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 Vital Care.

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.