SpecialtyCareRx

SPECIALTY CARE INFUSION CENTER

□ **Orange, CA**
P: (714) 941-6177 F: (714) 941-6178

□ **Burbank,CA**
P: (818) 848-8112 F: (818) 848-8142

□ **Las Vegas, NV**
P: (702) 790-4404 F: (702) 790-4406

□ **Marrero, LA**
P: (504) 340-5221 F: (504) 340-5228

□ **Allen, TX**
P: (469) 257-4200 F: (469) 795-9204

□ **Memphis, TN**
P: (901) 560-3580 F: (901) 560-3581

□ **Las Vegas, NV**
P: (702) 825-4900
F: (702) 977-8150

□ **Carson City, NV**
P: (702) 825-4900
F: (702) 977-8150

Rheumatology & Osteoarthritis Referral Form

Patient Information

Patient Name: _____ DOB: __/__/____
Sex: ☐Femal ☐Male SS#: ___-__-____ Language: _____
Allergies: _____ Wt: ____☐Kg☐Lb Ht: ____ □Cm □In
Addess: _____ Apt/Suite: _____
City: _____ State: _____ Zip: _____
Phone: _____ Contact: _____ Relation: _____
Email Address: _____

Prescriber Information

Prescriber Name: _____ NPI: _____
If Shipping to prescriber: □ Initial Fill □ Always □ Never
Addess: _____ Apt/Suite: _____
City: _____ State: _____ Zip_____
Phone: _____ Contact: _____
Fax: _____ Alt. Fax: _____
Email Address: _____

INSURANCE INFORMATION (or attach copy of cards)

Medical Plan: _____ Policy #: _____ Policy Holder: _____ Relationship: _____
Prescription Plan: _____ Policy #: _____ Policy Holder: _____ Relationship: _____

Clinical Information

Access Type:☐Peripheral ☐PICC □ PORT
Has patient previously been on therapy before? □ No □ Yes/Last Infusion:_____
Previously Tried Treatments/Medications for The Condition: _____

Prescription Information

□ Actemra®	□ Inject 162 mg subcut every week □ Inject 162 mg subcut every other week □ _____	□ 4 x 162 mg/0.9mL □ 2 x 162 mg/0.9mL □ _____	□ Pen □ PFS □ Vials
□ Benlysta®	□ 10 mg/kg or _____ mg IV at 2-Week intervals for the first 3 dose, then at 4-week intervals. □ 10 mg/kg or _____ mg IV every 4-weeks □ 28 □ 200mg subcut once weekly	□ 56 day supply (Induction) □ 28 day supply □ 4 x 200 mg/mL □ Pen	□ Vials □ PFS
□ Cimzia®	□ Inject 200 mg subcut at weeks 0, 2 and 4 □ Inject 200 mg subcut every 2 weeks □ Inject 400 mg subcut every 4 weeks	□ 6 x 200 mg/mL □ 2 x 200 mg/mL	□ PFS □ Vials
□ Cosentyx®	□ Inject 150 mg subcut once weekly at weeks 0, 1 ,2, and 3 □ Inject 300 mg subcut once weekly at weeks 0, 1 ,2, and 3 □ Inject 150 mg subcut on week 4 & every 4 weeks thereafter □ Inject 300 mg subcut on week 4 & every 4 weeks thereafter	□ 4 x 150 mg/mL □ 8 x 150 mg/mL □ 1 x 150 mg/mL □ 2 x 150 mg/mL	□ Pen □ PFS
□ Enbrel®	□ Inject 50 mg subcut every week	□ 4 x 50 mg/mL	□ SureClick □ Cartridge □ PFS
□ Humira®	□ Inject 40 mg subcut once weekly □ Inject 40 mg subcut every other week □ Inject 150 mg subcut every other week □ Inject 200 mg subcut every other week	□ 4 x 40 mg/0.4 mL CF □ 2 x 40 mg/0.4mL CF □ 2 x 150 mg/1.14mL □ 2 x 200 mg/1.14mL	□ Pen □ PFS □ Vials
□ Krystexxa®	□ 8 mg given as an IV infusion every two week for Gout	□ 2 x 8 mg/mL	□ Vials
□ Orencia®	□ Infuse _____ mg intravenously at week 0 only □ Infuse _____ mg intravenously at weeks 0 and 2 □ Infuse _____mg at week 4 and every 4 weeks thereafter	□ 28 day supply	□ Vials
□ Otezla®	□ Take as directed per package instructions □ Take 30 mg by mouth twice daily	□ 55 tablets □ 60 x 30 mg	□ Starter Pack □ Tablets

☐ Remicade®	Starting Dose	☐ 5 mg/kg ___mg IV at week 0,2,6	☐ ____Vials	
□ Inflectra®		□ 3 mg/kg ___mg IV at week 0,2,6		□ Vials
□ Renflexis®	Maintenance Dose	☐ _____mg/kg IV every _____ weeks	☐ ____Vials	
□ Rituxan®	□ Infuse _____ mg intravenously every _____ weeks		□ 28 day supply	□ Vials
□ Saphenlo®	□ Infuse 300 mg IV over 30 minutes every 4 weeks		□ 300 mg/2 mL	□ Vials
□ Simponi®	□ Inject 50 mg subcut once a month		□ 1 x 50 mg/0.5mL	□ SmartJect □ PFS
□ Simponi Aria®	□ Infuse _____ mg/kg or _____ mg IV over 30 minutes at weeks 0 □ Infuse _____ mg/kg or _____ mg IV over 30 minutes at week 4 and every 8 weeks thereafter			□ Vials
□ Stelara®	□ Inject 45 mg subcut on Day 1 (≤ 100 kg) □ Inject 90 mg subcut on Day 1 (> 100 kg) □ Inject 45 mg subcut on Day 29 & every 12 weeks thereafter □ Inject 90 mg subcut on Day 29 & every 12 weeks thereafter		□ 1 x 45 mg/0.5mL □ 1 x 90 mg/mL	□ PFS
□ Xeljanz®	□ Take 5 mg by mouth twice daily		□ 60 x 5 mg	□ Tablets
□ Zoledronic acid	□ Infuse 5 mg/100 mL IV over 30 minutes		□ 5mg/100 mL	□ 1 Yr supply
□ Others	☐ _____		☐ _____	☐ _____

Hydration and Pre-Medications

□ Hydration: NaCl 0.9% 250mL to infuse at a rate of 250mL/hr IV before & after infusion as hydration is needed.
□ Benadryl 25mg capsule: Take 1-2 caps by mouth 30-60 minutes prior to infusion & every 6 hours as needed post infusion.
□ Benadryl 50mg ampule: Infuse ____mg slow IVP 30 minutes prior to infusion
□ Tylenol 325mg: Take 1-2 tabs by mouth 30-60 minutes prior to infusion & every 6 hours as needed post infusion.
Not to exceed total daily dose of 3000mg.
□ Zofran 4mg ODT: Dissolve 1 tab on the tongue every 8 hours as needed for pre & post infusion for nausea and vomiting.
□ Solu-Cortef: Infuse _____mg slow IVP 30 minutes prior to infusion
□ Solu-Medrol: Infuse _____mg slow IVP 30 minutes prior to infusion

Flushing Protocol

□ Sodium Chloride 0.9% 5-10 ml pre and post medications
□ Heparin ____Units/mL OR ____mL as needed

Anaylaxis Protocol

MILD infusion reactions: (Slow infusion rate by 50% until symptoms resolve. Resume at previous rate as tolerated)
Diphenhydramine 25mg caps #4 Sig:Take 1-2 capsules PO Q6H PRN for infusion reactions, NTE total daily dose of 400mg (16 caps/day).
MODERATE infusion reactions: (Stop Infusion, resume at 50% rate when symptoms resolve)
Diphenhydramine 50mg/ml vial #1 Sig: Inject 1ml (=50mg) IV by slow IV push over 3-5 mins PRN for anaphylaxis reaction.
May repeat every 4 hrs, NTE 400mg/24hrs
SEVERE ANAPHYLAXIS *CALL 911* (Stop infusion and remove tubing from access device to prevent further administration)
1. Epinephrine 0.3mg Auto Injector #2 Sig: Remove cap then inject auto-injector intramuscularly in the thigh area and hold for 2 to 10 seconds as needed for anaphylaxis reaction, may administer through clothing if necessary. May repeat in 5-15-minutes.
2. Initiate 0.9% NaCl 500 mL IV x 1
3. Administer CPR if needed until EMS arrives

Ancillary Supplies : As needed for proper administration and disposal of medication

Skilled Nursing Visits: As needed for IV access, administration and proper clinical monitoring

Administration procedures to be followed per pharmacy protocol.

Prescription will be filled with generic (if available) unless prescriber writes "DAW" (dispense as written): _____

Deliver to: □ Home □ Office □ Infusion Suite □ Other: _____ **Refills: _____**

If shipped to prescriber's office or infusion clinic, prescriber accepts on behalf of patient for administration in office or infusion clinic.
By signing this order, I, the prescriber, certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment.

Prescriber's Signature _____ **Date: ___/___/_____**

* Prescriber Authorization: I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.
" Referral forms are not valid in Arizona, providers can phone or electronically send in orders."