

<input type="checkbox"/> Orange, CA P: (714) 941-6177 F: (714) 941-6178	<input type="checkbox"/> Burbank, CA P: (818) 848-8112 F: (818) 848-8142	<input type="checkbox"/> Las Vegas, NV P: (702) 825-4900 F: (702) 977-8150
<input type="checkbox"/> Las Vegas, NV P: (702) 790-4404 F: (702) 790-4406	<input type="checkbox"/> Marrero, LA P: (504) 340-5221 F: (504) 340-5228	
<input type="checkbox"/> Allen, TX P: (469) 257-4200 F: (469) 795-9204	<input type="checkbox"/> Memphis, TN P: (901) 560-3580 F: (901) 560-3581	<input type="checkbox"/> Carson City, NV P: (702) 825-4900 F: (702) 977-8150

Rheumatology & Osteoarthritis Referral Form

Patient Information		Prescriber Information	
Patient Name: _____	DOB: __/__/__	Prescriber Name: _____	NPI: _____
Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male	SS#: __-__-__	Language: _____	If Shipping to prescriber: <input type="checkbox"/> Initial Fill <input type="checkbox"/> Always <input type="checkbox"/> Never
Allergies: _____	Wt: ____ <input type="checkbox"/> Kg <input type="checkbox"/> Lb	Ht: ____ <input type="checkbox"/> Cm <input type="checkbox"/> In	Address: _____ Apt/Suite: _____
Address: _____		Apt/Suite: _____	City: _____ State: _____ Zip: _____
City: _____	State: _____	Zip: _____	Phone: _____ Contact: _____
Phone: _____	Contact: _____	Relation: _____	Fax: _____ Alt. Fax: _____
Email Address: _____		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

<input type="checkbox"/> Actemra®	<input type="checkbox"/> Inject 162 mg subcut every week	<input type="checkbox"/> 4 x 162 mg/0.9mL	<input type="checkbox"/> Pen
	<input type="checkbox"/> Inject 162 mg subcut every other week	<input type="checkbox"/> 2 x 162 mg/0.9mL	<input type="checkbox"/> PFS
	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> Vials
<input type="checkbox"/> Benlysta®	<input type="checkbox"/> 10 mg/kg or _____ mg IV at 2-Week intervals for the first 3 dose, then at 4-week intervals.	<input type="checkbox"/> 56 day supply (Induction)	<input type="checkbox"/> Vials
	<input type="checkbox"/> 10 mg/kg or _____ mg IV every 4-weeks <input type="checkbox"/> 28	<input type="checkbox"/> 28 day supply	
	<input type="checkbox"/> 200mg subcut once weekly	<input type="checkbox"/> 4 x 200 mg/mL	<input type="checkbox"/> Pen <input type="checkbox"/> PFS
<input type="checkbox"/> Cimzia®	<input type="checkbox"/> Inject 200 mg subcut at weeks 0, 2 and 4	<input type="checkbox"/> 6 x 200 mg/mL	<input type="checkbox"/> PFS
	<input type="checkbox"/> Inject 200 mg subcut every 2 weeks	<input type="checkbox"/> 2 x 200 mg/mL	<input type="checkbox"/> Vials
	<input type="checkbox"/> Inject 400 mg subcut every 4 weeks		
<input type="checkbox"/> Cosentyx®	<input type="checkbox"/> Inject 150 mg subcut once weekly at weeks 0, 1, 2, and 3	<input type="checkbox"/> 4 x 150 mg/mL	
	<input type="checkbox"/> Inject 300 mg subcut once weekly at weeks 0, 1, 2, and 3	<input type="checkbox"/> 8 x 150 mg/mL	<input type="checkbox"/> Pen
	<input type="checkbox"/> Inject 150 mg subcut on week 4 & every 4 weeks thereafter	<input type="checkbox"/> 1 x 150 mg/mL	<input type="checkbox"/> PFS
	<input type="checkbox"/> Inject 300 mg subcut on week 4 & every 4 weeks thereafter	<input type="checkbox"/> 2 x 150 mg/mL	
<input type="checkbox"/> Enbrel®	<input type="checkbox"/> Inject 50 mg subcut every week	<input type="checkbox"/> 4 x 50 mg/mL	<input type="checkbox"/> SureClick
			<input type="checkbox"/> Cartridge
			<input type="checkbox"/> PFS
<input type="checkbox"/> Humira®	<input type="checkbox"/> Inject 40 mg subcut once weekly	<input type="checkbox"/> 4 x 40 mg/0.4 mL CF	<input type="checkbox"/> Pen
	<input type="checkbox"/> Inject 40 mg subcut every other week	<input type="checkbox"/> 2 x 40 mg/0.4mL CF	<input type="checkbox"/> PFS
	<input type="checkbox"/> Inject 150 mg subcut every other week	<input type="checkbox"/> 2 x 150 mg/1.14mL	<input type="checkbox"/> Vials
	<input type="checkbox"/> Inject 200 mg subcut every other week	<input type="checkbox"/> 2 x 200 mg/1.14mL	
<input type="checkbox"/> Krystexxa®	<input type="checkbox"/> 8 mg given as an IV infusion every two week for Gout	<input type="checkbox"/> 2 x 8 mg/mL	<input type="checkbox"/> Vials
<input type="checkbox"/> Orencia®	<input type="checkbox"/> Infuse _____ mg intravenously at week 0 only		
	<input type="checkbox"/> Infuse _____ mg intravenously at weeks 0 and 2	<input type="checkbox"/> 28 day supply	<input type="checkbox"/> Vials
	<input type="checkbox"/> Infuse _____ mg at week 4 and every 4 weeks thereafter		
<input type="checkbox"/> Otezla®	<input type="checkbox"/> Take as directed per package instructions	<input type="checkbox"/> 55 tablets	<input type="checkbox"/> Starter Pack
	<input type="checkbox"/> Take 30 mg by mouth twice daily	<input type="checkbox"/> 60 x 30 mg	<input type="checkbox"/> Tablets
<input type="checkbox"/> Remicade®	Starting Dose <input type="checkbox"/> 5 mg/kg _____ mg IV at week 0,2,6	<input type="checkbox"/> _____ Vials	
<input type="checkbox"/> Inflectra®	Maintenance Dose <input type="checkbox"/> 3 mg/kg _____ mg IV at week 0,2,6		<input type="checkbox"/> Vials
<input type="checkbox"/> Renflexis®	<input type="checkbox"/> _____ mg/kg IV every _____ weeks	<input type="checkbox"/> _____ Vials	
<input type="checkbox"/> Rituxan®	<input type="checkbox"/> Infuse _____ mg intravenously every _____ weeks	<input type="checkbox"/> 28 day supply	<input type="checkbox"/> Vials
<input type="checkbox"/> Saphenlo®	<input type="checkbox"/> Infuse 300 mg IV over 30 minutes every 4 weeks	<input type="checkbox"/> 300 mg/2 mL	<input type="checkbox"/> Vials

<input type="checkbox"/> Simponi®	<input type="checkbox"/> Inject 50 mg subcut once a month	<input type="checkbox"/> 1 x 50 mg/0.5mL	<input type="checkbox"/> SmartJect <input type="checkbox"/> PFS
<input type="checkbox"/> Simponi Aria®	<input type="checkbox"/> Infuse _____ mg/kg or _____ mg IV over 30 minutes at weeks 0 <input type="checkbox"/> Infuse _____ mg/kg or _____ mg IV over 30 minutes at week 4 and every 8 weeks thereafter		<input type="checkbox"/> Vials
<input type="checkbox"/> Stelara®	<input type="checkbox"/> Inject 45 mg subcut on Day 1 (\leq 100 kg) <input type="checkbox"/> Inject 90 mg subcut on Day 1 ($>$ 100 kg) <input type="checkbox"/> Inject 45 mg subcut on Day 29 & every 12 weeks thereafter <input type="checkbox"/> Inject 90 mg subcut on Day 29 & every 12 weeks thereafter	<input type="checkbox"/> 1 x 45 mg/0.5mL <input type="checkbox"/> 1 x 90 mg/mL	<input type="checkbox"/> PFS
<input type="checkbox"/> Xeljanz®	<input type="checkbox"/> Take 5 mg by mouth twice daily	<input type="checkbox"/> 60 x 5 mg	<input type="checkbox"/> Tablets
<input type="checkbox"/> Zoledronic acid	<input type="checkbox"/> Infuse 5 mg/100 mL IV over 30 minutes	<input type="checkbox"/> 5mg/100 mL	<input type="checkbox"/> 1 Yr supply
<input type="checkbox"/> Others	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____

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

Anaphylaxis 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."