Date Shipment Needed: _____ Ship To: ❑Patient ❑Prescriber
❑ Nursing needed; ❑Training needed ► All the supplies including syringes and needles will be dispensed if needed.

RHEUMATOLOGY IV ROUTE REFERRAL FORM

PATIENT INFORMATION

Patient Name:		DOB:	Sex: ❑M ❑F	Weight:	❑lbs. ❑kg.
SSN:	Phone:	Allergies:			
Address:		City:	State:	Zip:	
Emergency Contact:		Phone:	❑ **Please attach demographic information**		

PRESCRIBER INFORMATION

Prescriber:	NPI:	DEA:	State Lic:
Supervising Physician:		Practice Name:	
Address:		City:	State:	Zip:
Phone:	Fax:	Key Office Contact:	Phone:

DIAGNOSIS INFORMATION / MEDICAL ASSESMENT

Primary Diagnosis: ❑M06.9 Rheumatoid Arthritis ❑L40.54; L40.59 Psoriatic Arthritis ❑M08.00 Polyarticular Juvenile Rheumatoid Arthritis ❑M08.00 Juvenile Idiopathic Arthritis
❑M45.9 Ankylosing Spondylitis ❑M45.9 Ankylosing Spondylitis ❑M33.20 Polmyositis ❑M15.0 - M15.9 Osteoarthritis ❑Other: _____

- Has patient been treated *previously* for this condition? ❑Yes ❑No Is patient *currently* on therapy? ❑Yes ❑No Medications: _____
- Is patient currently on therapy? ❑Yes ❑No If *yes*, how long should patient wait before starting the new medication? _____
- Will patient stop taking the above medication(s) before starting the new medication? ❑Yes ❑No If *yes*, how long should patient wait before starting the new medication? _____
- Other medications patient is currently taking including OTC medications with dosage and direction (or fax medication profile): _____
- Has patient received a **Quatiferon gold**, **Tspot**, or **PPD (tuberculosis) Skin Test**? ❑Yes ❑No Date: _____ Results: ❑Negative ❑Positive

Prior to initiating treatment and periodically during therapy, patient should be evaluated for active tuberculosis and tested for latent infection

INSURANCE INFORMATION

❑ **Please attach front and back of patient's insurance card (medical and prescription)**

COPAY CARD ENROLLMENT

❑ **Please check if enrolling in copay card** | **Copay ID:**

PRESCRIPTION INFORMATION

❑**Actemra® 20 mg/mL (Vial Sizes: 4 mL, 10 mL, 20 mL)** **Maximum dose per infusion is 800 mg* — ❑**Enroll in Access Solutions**
- ❑Starter Dose: 4 mg/kg _____ mg IV every 4 weeks, infusion over 60 minutes (infusion at MD's office or infusion center) — QTY: QS — Refills:____
- ❑Maintenance Dose: 8 mg/kg _____ mg IV every 4 weeks, infusion over 60 minutes (infusion at MD's office or infusion center) — QTY: QS — Refills:____
- ❑Alternate Dose: _____

❑**Epipen® 0.3 mg IM x 1, may repeat #2** ❑**Epipen® Jr. for Pediatrics less than 30 kg, 0.15 mg IM x 1, may repeat** — QTY:____ — Refills:____
**In the case of anaphylaxis, inj. in anterolateral thigh area #2*

❑**IVIG**
- ❑Home Infusion *(please go to www.AcariaHealth.com to download IVIG referral form, or ask your local AcariaHealth representative)* — QTY:____ — Refills:____
- ❑MD's office infusion ❑Infusion supplies needed — QTY: QS — Refills:____
- ❑Dosage: _____ — QTY: QS — Refills:____

❑**Kevzara® 200 mg/1.14mL Prefilled Syringe,** 200 mg SQ every 2 weeks — QTY: 1 box (2 syringes) — Refills:____

❑**Orencia®** IV 250 mg Vial for IV *Dosage based on patient's weight ❑MD's office infusion ❑Infusion supplies needed — ❑**Enroll in The Circle Program**
- ❑Administer 125mg by subcutaneous injection once weekly with or without an intravenous loading dose. — QTY:____ — Refills:____
- ❑For patients initiating therapy with an IV loading dose, administer a single IV infusion (per Kg categories above), followed by the first 125 mg subcutaneous injection given within a day of the IV infusion — QTY:____ — Refills:____

❑**Orencia® ClickJet Autoinjector** — QTY:____ — Refills:____
- ❑Administer 125mg by subcutaneous injection once weekly with or without an intravenous loading dose.
- ❑For patients initiating therapy with an IV loading dose, administer a single IV infusion (per Kg categories above), followed by the first 125 mg subcutaneous injection given within a day of the IV infusion

❑**Remicade® 100 mg Vial** ❑MD's office infusion ❑Infusion supplies needed — ❑**Enroll in AccessOne Program**
- ❑Starter Dose: _____ mg/kg _____mg IV on: Week 0, 2, 6, then follow maintenance dosing instructions — QTY:___ — Refills:____
- ❑Maintenance Dose: _____ mg/kg _____ mg IV every _____ weeks for _____ infusions — QTY:___ — Refills:____

❑**Rituxan® 1000 mg IV Infusion as Directed (MD's Office Infusion)** — ❑**Enroll in RISE Program**
- ❑Day 1 ❑Day 15 (*will dispense available vial size*) ❑Other: _____ — QTY: QS — Refills:____

❑**Simponi® Aria 50 mg/4 mL Single-use Vial** — ❑**Enroll in RISE Program**
- ❑Starting Dose: 2 mg/kg _____ mg IV at Weeks 0 and 4, infusion over 30 minutes — QTY: QS — Refills:____
- ❑Maintenance Dose: 2 mg/kg _____ mg IV every 8 weeks, infusion over 30 minutes — QTY: QS — Refills:____
- ❑Alternate Dose: _____ — QTY: QS — Refills:____

❑**Other**
- ❑Dosage: _____ — QTY: ___ — Refills:____

Prescriber's Signature: _____ ❑ DAW (Dispense as Written) **Date:** _____

Prescriber certifies that this referral form contains an original signature and is signed by the treating prescriber. NO STAMPED SIGNATURES WILL BE ACCEPTED. Where required by law, send electronic prescription or on official state prescription blank. In the event requested agent is not available through the receiving pharmacy, this prescription shall be forwarded to an eligible pharmacy.

Rev: 20230606