Rheumatology Oral/ SC
REFERRAL FORM

FAX REFERRAL TO: +1(844) 277-0049 **PHONE:** +1(844) 650-5802

IV Solutions RX

1 PATIENT'S INFORMATION *(Complete or include demographic sheet)*

Patient Name: _____ **DOB:** _____ **Gender:** ☐ MALE ☐ FEMALE
Address: _____ **City/State/Zip:** _____
Primary Phone: _____ **Email:** _____ **SSN:** _____ **Primary Language:** _____
Emergency Contact: _____ **Relationship to Patient:** _____ **Phone:** _____

2 INSURANCE *(Please attach **If Available** a copy of the Patient's' insurance card(s) Front/ Back)*

Primary Insurance: _____ **Policy No:** _____ **Group:** _____
Primary RX Insurance: _____ **ID No:** _____ **RX GRP:** _____ **RX BIN:** _____ **RX PCN:** _____

3 DIAGNOSIS AND CLINICAL INFORMATION

First time receiving Therapy? ☐ Yes ☐ No **If No, previous product used:** _____ **Last Dose Given:** _____

Diagnosis (ICD-10):

☐ H44.139 Uveitis, unspecified ey
☐ L40.50 Arthropathic Psoriasis, Unspecified
☐ L40.54 Juvenile Psoriatic Arthritis (JPsA)
☐ M08.00 Juvenile Idiopathic Arthritis (JIA)
☐ M06.9 Rheumatoid Arthritis (RA)
☐ M35.3 Polymyalgia Rheumatica (PMR)
☐ M45.9 Ankylosing Spondylitis (AS)
☐ M45.A0 Non-Radiographic Axial Spondylarthritis (nr-axSpA)
☐ Other: _____ Description: _____

Patient Clinical Information:

Drug Allergies: _____ ☐ NKDA **Ht:** _____ in/cm **Wt:** _____ lbs/Kg
TB Test Date: _____ ☐ Positive**(+)** ☐ Negative**(-)** **Hepatitis-B Test Date:** _____ ☐ Positive**(+)** ☐ Non-Reactive**(-)**

Labs: Please fax copy of the following labs dated within 1 year of the patients referral request:
☐ **CMP** ☐ **CBC w/ diff** ☐ **Hepatitis-(B)** ☐ **QuantiFERON-***(QFT)***/ T-Spot**

4 PRESCRIPTION INFORMATION

ACCESS: ☐ **SC** ☐ **Not Applicable** (N/A)

RX INFORMATION: Our pharmacist will identify clinically appropriate brand *(Unless product is specifically specified at the time of referral)* and infusion rate per FDA guidelines. Clinically appropriate substitutions may be allowed based on availability or payor requirements. Round dose(s) to the nearest vial size. Official orders will be outlined with "May Infuse" +/- 3 days if scheduling needs arises, with insurance payor approval".

PRODUCT: ☐ Actemra ☐ Adalimumab-_____ ☐ Enbrel ☐ Humira ☐ Ilaris ☐ Kevzara ☐ Orencia ☐ Simponi ☐ Skyrizi ☐ Taltz ☐ Tremfya
ORAL PRODUCT: ☐ Otezla ☐ Rinvoq ☐ Xeljanz ☐ Xeljanz XR ☐ Other: _____

DOSE & DIRECTIONS

LOADING DOSE: _____

MAINTENANCE DOSE: _____

PRE/POST ORDERS:

MEDICATION	DIRECTION	QUANTITY	REFILLS
☐ Diphenhydramine **(PO)**	Administer _____ mg 30-60 min Prior to Infusion. May repeat every _____ hours PRN.	Quantity: **Q.S**	Refills: **PRN**
☐ Acetaminophen **(PO)**	Administer _____ mg PO 30-60 min Prior to Infusion. May repeat every _____ hours PRN.	Quantity: **Q.S**	Refills: **PRN**

ANAPHYLAXIS PROTOCOL:

MEDICATION	DIRECTION	QUANTITY	REFILLS
☒ EPINEPHRINE **(autoinjector)**	Administer IM for severe anaphylactic reaction. May repeat in 5-15 minutes ☐ ***0.3 mg (Wt > 30 kg)*** ☐ ***0.15 mg (Wt 15-30 kg)*** ☐ ***0.1 mg (Wt 7.5-15 kg)***	Quantity: **(x2) Pen(s)**	Refills: **PRN**

THERAPY SUPPLIES:

☒ **INFUSION SUPPLIES:** Infusion supplies, and infusion pump PRN for the reconstitution, administration, and disposal of medication.

5 PRESCRIBER INFORMATION

Prescriber Name: _____ **Title:** ☐ **MD** ☐ **DO** ☐ **ND** ☐ **PA** ☐ **APRN** **NPI:** _____
Address: _____ **City/State/Zip:** _____
Phone: _____ **Fax:** _____ **Contact Person:** _____

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record.
I authorize IV Solutions RX and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future refills of the same prescription for the patient listed above. I understand that I can revoke the designation at any time by providing written notice to IV Solutions RX.
CONFIDENTIALITY NOTICE: The information contained in this transmission may contain confidential information, including patient information protected by federal and state privacy laws. It is intended only for the use of the person(s) named above. If not the intended recipient, you are hereby notified that any review, dissemination, distribution, or duplication of this communication is strictly prohibited. If you are not the intended recipient, please contact the sender by reply email to **info@ivsolutionsrx.com** and destroy all copies of the original message.

_____ **Prescribers signature** _____ **Date**

THANK YOU FOR YOU TRUSTING US WITH YOUR PATIENTS SPECIALTY CARE *#welcome to our family*

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