Rheumatology IV
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):

- ☐ L40.50 Arthropathic Psoriasis, Unspecified
- ☐ L40.59 Other Psoriatic Arthropathy
- ☐ M06.9 Rheumatoid Arthritis, Unspecified
- ☐ M08.00 Unspecified Juvenile Rheumatoid Arthritis of Unspecified Site
- ☐ M08.90 Polyarticular Juvenile Idiopathic Arthritis (PJIA)
- ☐ M08.20 Systemic Juvenile Idiopathic Arthritis (SJIA)
- ☐ M31.6 Giant Cell Arteritis (GCA)
- ☐ M45.9 Non-Radiographic Axial Spondylarthritis (nr-axSpA)
- ☐ M45.A0 Ankylosing Spondylitis of Unspecified Sites in Spine
- ☐ 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: ☐ IV ☐ PORT

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 ☐ Avsola ☐ Inflectra ☐ InFLIXimab ☐ Orencia ☐ Remicade ☐ Renflexis ☐ Simponi ARIA ☐ Other: _____

DOSE & DIRECTIONS

LOADING DOSE: _____

MAINTENANCE DOSE: _____

PRE/POST ORDERS:

MEDICATION	DIRECTION	QUANTITY	REFILLS
☐ SoluMedrol® **(IV)**	Give _____ mg prior to infusion via ☐ IV push ☐ diluted in _____ mL of NS over 30 min.	Quantity: **Q.S**	Refills: **PRN**
☐ Diphenhydramine: ☐ **PO** ☐ **IV**	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**
☐ Hydration: ☐ 0.9% NaCL ☐ LR	Infuse _____ mL of _____ solution ☐ before ☐ after infusion.	Quantity: **Q.S**	Refills: **PRN**

ANAPHYLAXIS PROTOCOL:

MEDICATION	DIRECTION	QUANTITY	REFILLS
☒ EPINEPHRINE **(vial or 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: **(x1) Vial** or **(x2) Pen(s)**	Refills: **PRN**
☒ DIPHENHYDRAMINE **(50mg/mL)**	Administer via IM or slow IV push for severe anaphylactic reaction. ☐ ***50 mg (Wt > 30 kg)*** ☐ ***25 mg (Wt 15-30 kg)*** ☐ ***12.5mg (Wt 7.5-15kg)***	Quantity: **(x1) Vial(s)**	Refills: **PRN**
☒ SODIUM CHLORIDE 0.9% **(IV)**	Infuse 500 mL IV as directed for severe anaphylactic reaction.	Quantity: **500 mL**	Refills: **PRN**

NURSING/ LABS/ INFUSION SUPPLIES:

☒ **NURSING:** Nursing visits with each infusion to establish venous access, administer medication, assess and monitor patient, provide education, and complete lab draws.

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

FLUSHING PROTOCOL: ☒ Sodium chloride 0.9%, Up to 10 mL before/after medication, and/or PRN to maintain patency.
Heparin: ☐ 10 Units/mL ☐ 100 Units/mL, _____ as final flush and/or PRN to maintain patency

☒ **LABS:** [Dx code: Z79.899] Labs as follows, to be drawn annually by RN prior to infusion unless frequency is specified: every _____ month(s)
☐ CMP ☐ CBC w/ diff ☐ Hep-(B) ☐ Other: _____

☒ **LABS:** TB test shall be ordered at a frequency deemed appropriate and performed by an outside lab facility.

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.
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Physicians signature **Date**

THANK YOU FOR YOU TRUSTING US WITH YOUR PATIENTS SPECIALTY CARE

#welcome to our family

5315 Avion Park Drive, Suite 120 Tampa, Florida 33607