Rheumatology Oral/ SC REFERRAL FORM

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

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 SIGNATURE REQUIRED *(STAMP SIGNATURE NOT ALLOWED)*

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

☐ DISPENSE AS WRITTEN ☐ BRAND MEDICALLY NECESSARY ☐ DO NOT SUBSTITUTE ☐ NO SUBSTITUTION / ☐ DAW / ☐ MAY NOT SUBSTITUTE	☐ May Substitute / ☐ Product Selection Permitted / ☐ Substitution Permissible
Prescriber's Signature: ________ **Date:** ________	**Prescriber's Signature:** ________ **Date:** ________

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "No Substitution." NY & IA: electronic prescription required.

Prescribers are to comply with state-specific prescription regulations, which may include requirements for electronic prescribing, generic substitution, authorized prescription formats, and fax language. Noncompliance with these requirements may prompt follow-up communication with the prescriber.

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.

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