Phone: 800.511.5144 • Fax: 877.541.1503

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 ☐ Other:	Weight:	☐ lbs. ☐ kg.
SSN:	Phone:	Allergies:			
Address:		City:	State:	Zip:	
Emergency Contact:		Phone:	☐ **Additional Information Attached**		

PRESCRIBER INFORMATION

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

DIAGNOSIS INFORMATION / MEDICAL ASSESSMENT

Primary Diagnosis: ☐ M06.9 Rheumatoid Arthritis ☐ L40.54; L40.59 Psoriatic Arthritis ☐ M08.00 Unspecified Juvenile Rheumatoid Arthritis ☐ M08.20 Juvenile Idiopathic Arthritis
☐ M08.3 Juvenile Rheumatoid Polyarthritis (Seronegative) ☐ M45.9 Ankylosing Spondylitis ☐ M33.20 Polymyositis ☐ M15.0 - M15.9 Osteoarthritis ☐ Other:_____

- Has patient been treated *previously* for this condition? ☐ Yes ☐ No Is patient *currently* on therapy? ☐ Yes ☐ No Please list medication(s) and treatment duration:
  _____
- 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

☐ **STC Standard Protocol** will include the following: (1) dispensing ordered med/dose, (2) diluent to mix and/or dilute dose, (3) flushes to flush line and anakit med (epinephrine 0.3 mg IM/0.15 mg IM (for pediatric patients) and diphenhydramine 50 mg/mL) and (4) premeds to take 30 mins before orally (Apap 325 mg, may repeat x1, and diphenhydramine 25 mg, may repeat x1).

☐ **Actemra® 20 mg/mL (Vial Sizes: 4 mL, 10 mL, 20 mL)** **Maximum dose per infusion is 800 mg* ☐ Starter Dose Not Needed — ☐ **Enroll in Access Solutions**
- ☐ *Standard Dose:* 4 mg/kg _____ mg IV every 4 weeks, infusion over 60 minutes (infusion at MD's office or infusion center) — QTY: QS | Refills:
- ☐ *Increased 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:* _____ — QTY: _____ | Refills:

☐ **IVIG**
- ☐ Home Infusion *(Download IVIG referral form at www.AcariaHealth.com, or ask your local AcariaHealth rep)*

☐ **Orencia® 250 mg IV Vial** *Dosage based on patient's weight ☐ MD's office infusion ☐ Infusion supplies needed — ☐ **Enroll in The Circle Program**
- ☐ Infuse _____ mg at Weeks 0, 2 and 4, then every 4 weeks thereafter — QTY: _____ | Refills:

Remicade® and Remicade® Biosimilars (Inflectra®, Renfexis®, Avsola®)
☐ **Remicade® 100 mg vial** ☐ **Inflectra® 100 mg vial** ☐ **Renflexis® 100 mg vial** ☐ **Avsola® 100 mg vial** — ☐ **Enroll in AccessOneSM Program**
- ☐ MD's Office Infusion ☐ Infusion Supplies Required
- ☐ Infuse _____ mg IV on Weeks 0, 2, and 6 — QTY: QS for Approp. Amt. | Refills: 0
- ☐ Infuse _____ mg IV every 8 weeks — QTY: QS for Approp. Amt. | Refills:
- ☐ Infuse _____ mg IV every _____ weeks — QTY: QS for Approp. Amt. | Refills:

Rituxan® and Rituxan® Biosimilars (Truxima®, Ruxience®, Riabni®)
☐ **Rituxan® 500 mg vial** ☐ **Truxima® 500 mg vial** ☐ **Ruxience® 500 mg vial** ☐ **Riabni® 500 mg vial** — ☐ **Enroll in RISE Program**
- ☐ Infuse 1000 mg IV once every 2 weeks for 2 doses, every 16 to 24 weeks — QTY: 4 Vials | Refills:
- ☐ Other: _____ — QTY: QS | Refills:

☐ **Simponi® Aria 50 mg/4 mL Single-use Vial** ☐ Starter Dose Not Needed
- ☐ *Starter Dose:* 2 mg/kg _____ mg IV on 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:** _____ — 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 AcariaHealth, this prescription shall be forwarded to an eligible pharmacy.