Rheumatology Therapies

Please fax completed referral form to 972-473-7563

PATIENT DEMOGRAPHIC INFORMATION

Patient's name: _____ Date of birth: _____ Phone #: _____

Address: _____ City/State/Zip: _____

Allergies: _____ Weight: _____ Height: _____

DIAGNOSIS & CLINICAL INFORMATION

Diagnosis: *(ICD 10 Code Required)*

☐ Arthropathic Psoriasis (L40.50-L40.59), ICD 10_____ ☐ Rheumatoid Arthritis with Rheumatoid Factor (M05.70-M05.9), ICD 10_____

☐ Rheumatoid Arthritis without Rheumatoid Factor (M06.00-M06.09), ICD 10_____ ☐ Rheumatoid Arthritis, Unspecified (M06.9), ICD 10_____

☐ Juvenile Rheumatoid Arthritis (M08.00-M08.99), ICD 10_____ ☐ Ankylosing Spondylitis (M45.0-M45.9), ICD 10_____

☐ Systemic Lupus Erythematosus (M32.0-M32.9), ICD 10_____ ☐ Other: _____

Prior Failed Therapy:

Med Failed: _____ Length of Treatment: _____ Reason for D/C: _____

Med Failed: _____ Length of Treatment: _____ Reason for D/C: _____

Med Failed: _____ Length of Treatment: _____ Reason for D/C: _____

Test Results: Please attach copy for all items checked.

☐ Negative TB Test

☐ Autoantibody test (ANA, anti-dsDNA) for SLE

☐ Other: _____

Please include copy of insurance card, most recent H&P or MD note, medication list, and lab results.

THERAPY ORDERED

MEDICATION	DOSE	DIRECTIONS/DURATION
Actemra® (tocilizumab)	☐ **4mg/kg:** _____mg ☐ **8mg/kg:** _____mg	☐ Infuse IV every 4 weeks x 1 year
Benlysta® (belimumab)	_____mg (10mg/kg)	☐ **LOADING:** Infuse IV at Weeks 0, 2, and 4 ☐ **MAINTENANCE:** Infuse IV every 4 weeks x 1 year
Cimzia® (certolizumab pegol)	**INITIAL:** 400mg **MAINTENANCE:** ☐ 400mg ☐ 200mg	☐ **INITIAL:** Inject 400mg SUBQ at Weeks 0, 2, and 4 ☐ **MAINTENANCE:** Inject 400mg SUBQ every 4 weeks x 1 year ☐ **MAINTENANCE:** Inject 200mg SUBQ every 2 weeks x 1 year
Orencia® (abatacept)	☐ **<60kg:** 500mg ☐ **60-100kg:** 750mg ☐ **>100kg:** 1000mg	☐ **INITIAL:** Infuse IV at Weeks 0, 2, and 4 ☐ **MAINTENANCE:** Infuse IV every 4 weeks x 1 year
Simponi Aria™ (golimumab)	_____mg (2mg/kg)	☐ **LOADING:** Infuse IV at Weeks 0 and 4 ☐ **MAINTENANCE:** Infuse IV every 8 weeks x 1 year
Rituxan® (rituximab)	1000mg	☐ Infuse IV on Days 1 and 15 every _____ weeks x 1 year
☐ Remicade® (infliximab) ☐ Renflexis® (infliximab-abda) ☐ Inflectra® (infliximab-dyyb)	☐ **5mg/kg:** _____mg ☐ **10mg/kg:** _____mg ☐ **Other:** _____mg	☐ **INITIAL:** Infuse IV at Weeks 0, 2, and 6 ☐ **MAINTENANCE:** Infuse IV every 8 weeks x 1 year ☐ **MAINTENANCE:** Infuse IV every ____ weeks x 1 year
OTHER:		
OTHER:		

Is patient currently receiving therapy above from another facility? ☐ **NO** ☐ **YES** If yes, Facility Name: _____

REFERRING PHYSICIAN INFORMATION

Physician Name: _____ Specialty: _____

Address: _____ City/State/Zip: _____

Office Contact: _____ Phone #: _____ Fax #: _____

AIR Care
Allergy, Immunology & Respiratory Care

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