

# Rheumatology Therapies

Please fax completed referral form to 281-295-4088

## 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  Other: \_\_\_\_\_  
 Autoantibody test (ANA, anti-dsDNA) for SLE

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

## THERAPY ORDERED

MEDICATION	DOSE	DIRECTIONS/DURATION
<input type="checkbox"/> Actemra® (tocilizumab) <input type="checkbox"/> Tofidence® (tocilizumab-bavi) <input type="checkbox"/> Tyenne® (tocilizumab-aazg)	<input type="checkbox"/> <b>4mg/kg:</b> _____ mg <input type="checkbox"/> <b>8mg/kg:</b> _____ mg	<input type="checkbox"/> Infuse IV every 4 weeks x 1 year
Benlysta® (belimumab)	_____ mg (10mg/kg)	<input type="checkbox"/> <b>INITIAL:</b> Infuse IV at Weeks 0, 2, and 4 <input type="checkbox"/> <b>MAINTENANCE:</b> Infuse IV every 4 weeks x 1 year
Cimzia® (certolizumab pegol)	<b>INITIAL:</b> 400mg <b>MAINTENANCE:</b> <input type="checkbox"/> 400mg <input type="checkbox"/> 200mg	<input type="checkbox"/> <b>INITIAL:</b> Inject 400mg SUBQ at Weeks 0, 2, and 4 <input type="checkbox"/> <b>MAINTENANCE:</b> Inject 400mg SUBQ every 4 weeks x 1 year <input type="checkbox"/> <b>MAINTENANCE:</b> Inject 200mg SUBQ every 2 weeks x 1 year
Cosentyx® IV (secukinumab)	<input type="checkbox"/> <b>INITIAL:</b> _____ mg (6mg/kg) <input type="checkbox"/> <b>MAINTENANCE:</b> _____ mg (1.75mg/kg; MAXIMUM = 300mg)	<input type="checkbox"/> <b>INITIAL:</b> Infuse IV x 1 dose <input type="checkbox"/> <b>MAINTENANCE:</b> Infuse IV every 4 weeks x 1 year
Orencia® (abatacept)	<input type="checkbox"/> <b>&lt;60kg:</b> 500mg <input type="checkbox"/> <b>60-100kg:</b> 750mg <input type="checkbox"/> <b>&gt;100kg:</b> 1000mg	<input type="checkbox"/> <b>INITIAL:</b> Infuse IV at Weeks 0, 2, and 4 <input type="checkbox"/> <b>MAINTENANCE:</b> Infuse IV every 4 weeks x 1 year
Rituxan® (rituximab)	1000mg	<input type="checkbox"/> Infuse IV on Days 1 and 15 every _____ weeks x 1 year
<input type="checkbox"/> Remicade® (infliximab) <input type="checkbox"/> Renflexis® (infliximab-abda) <input type="checkbox"/> Inflectra® (infliximab-dyyb)	<input type="checkbox"/> <b>3mg/kg:</b> _____ mg <input type="checkbox"/> <b>5mg/kg:</b> _____ mg <input type="checkbox"/> <b>10mg/kg:</b> _____ mg <input type="checkbox"/> <b>Other:</b> _____ mg	<input type="checkbox"/> <b>INITIAL:</b> Infuse IV at Weeks 0, 2, and 6 <input type="checkbox"/> <b>MAINTENANCE:</b> Infuse IV every 8 weeks x 1 year <input type="checkbox"/> <b>MAINTENANCE:</b> Infuse IV every _____ weeks x 1 year
Simponi Aria® (golimumab)	_____ mg (2mg/kg)	<input type="checkbox"/> <b>INITIAL:</b> Infuse IV at Weeks 0 and 4 <input type="checkbox"/> <b>MAINTENANCE:</b> Infuse IV every 8 weeks x 1 year
Saphnelo® (anifrolumab)	300mg	<input type="checkbox"/> Infuse IV every 4 weeks x 1 year
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 #: \_\_\_\_\_



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