Rheumatology Infusion Referral Form
Fax #: _____

Patient Information

Patient Name: _____ DOB: _____ SS#: _____ Ship To: □ Home □ Clinic

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Please Attach a Demographics Page & Copy of Insurance Card with this Prescription if Available:

1. **Diagnosis:** □ M06.9 Rheumatoid Arthritis □ L40.50 Psoriatic Arthritis □ Ankylosing Spondylitis □ Other: _____
2. **Drug Allergies:** _____
3. **Failed Medications:** □ Methotrexate Therapy Length:_____ Discontinuation Reason: _____
   □ _____ Therapy Length:_____ Discontinuation Reason: _____
4. **Negative TB Skin Test (PPD Test):** □ Yes □ No When: _____ (Please Attach)

Medication

Simponi ARIA
Induction Dosage: _____ mg over 30 minutes at weeks 0 and 4 Quantity: 30 day supply Refill: _____
Maintenance Dosage: _____ mg every 8 weeks thereafter

Remicade (infliximab)
Induction Dosage: _____ mg at weeks 0,2, and 6 Quantity: 30 day supply Refills: _____
Maintenance Dosage: _____ mg every 6 weeks thereafter
Other Dosage: _____

Rituxan (rituximab)
Infuse _____ mg on Day 1 and Day 15 Quantity: 30 day supply Refills: _____
Dispense: ____ 100 mg vials ___ 500 mg vials
Other Dosage: _____

Orencia (abatacept)
Induction Dosage: _____ mg at weeks 0, 2, and 6 Quantity: 30 day supply Refills: _____
Maintenance Dosage: _____ mg every 4 weeks thereafter
Other Dosage: _____

Benlysta (belimumab)
Induction Dosage: _____ mg at weeks 0, 2, and 4 Quantity: 30 day supply Refills: _____
Maintenance Dosage: _____ mg every 4 weeks thereafter

Physician Prescription Orders

Physician Name: _____ NPI #: _____ Phone: _____ Fax: _____

Address: _____ Nurse: _____ Date: _____

Physician Signature: _____