# RHEUMATOID ARTHRITIS REFERRAL FORM

Date: _____

**LOTUS HEALTH INFUSIONS**
**Fax Referral To: 877-643-0993**
**Phone: 832-284-4452**

Needs by Date: _____ Ship to ☐ Patient's Home ☐ Prescriber 1st Order Only ☐ Prescriber All Orders

## PATIENT INFORMATION

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Cell Phone: _____
Date of Birth: _____ Gender: ☐ M ☐ F

## PRESCRIBER INFORMATION

Prescriber Name: _____
Address: _____
City, State, Zip: _____
Phone: _____ Fax: _____
DEA#: _____ NPI#: _____
Contact Person: _____

## INSURANCE INFORMATION *(Please attach the front and back of insurance and prescription drug card)*

Primary Insurance: _____ ID#: _____ Group: _____
Secondary Insurance: _____ ID#: _____ Group: _____
Prescription Card: _____ ID#: _____ BIN: _____ PCN: _____ Group: _____

## DIAGNOSIS & CLINICAL ASSESSMENT *(Fill in below or attach lab work)*

**Primary Diagnosis Code & Condition**: _____ **Joints Affected**: _____

**Number of Tender Joints**: _____ **Number of Swollen Joints**: _____ **Current Weight**: _____ **Date**: _____

☐ **New Therapy Induction |** Stop Date: _____ ☐ **Therapy Change |** Stop Date: _____

☐ **Therapy Continuation |** Stop Date: _____ **Weeks Completed**: ☐ 0 ☐ 2 ☐ 4 ☐ 6 **Allergies**: _____

**ESR & Date**: _____ **CRP & Date**: _____ **TB Results & Date**: _____

### Actemra® (tocilizumab)

☐ 80 mg/4 mL Vial ☐ 162 mg Syringe
☐ 200 mg/10 mL Vial ☐ 400 mg/20 mL Vial
**SIG:** _____
QTY: _____ Refill: _____

### Enbrel® (etanercept)

☐ 25 mg Syringe ☐ 25 mg Vial
☐ 50 mg Syringe ☐ 50 mg SureClick Pen
**SIG:** _____
QTY: _____ Refill: _____

### Humira® (adalimumab)

☐ 10 mg Syringe ☐ 20 mg Syringe
☐ 40 mg Syringe ☐ 40 mg Pen
**SIG:** _____
QTY: _____ Refill: _____

### Cimzia® (certolizumab pegol)

☐ 2 x 200 mg Kit ☐ Syringe ☐ Vial
**SIG:** _____
QTY: _____ Refill: _____

### Kineret® (anakinra)

☐ 100 mg Syringe
**SIG:** _____
QTY: _____ Refill: _____

### Prolia® (denosumab)

☐ 60 mg PFS ☐ 60 mg Vial
**SIG:** _____
QTY: _____ Refill: _____
Bone Density Score: _____
Date of Test: _____

### Remicade® (infliximab)

☐ 100 mg Vial
**SIG:** _____
QTY: _____ Refill: _____

### Rituxan® (rituximab)

☐ 100 mg Vial ☐ 500 mg Vial
**SIG:** _____
QTY: _____ Refill: _____

### Orencia® (abatacept)

☐ (4) 125 mg Prefilled Syringe ☐ 250mg Vial
**SIG:** _____
QTY: _____ Refill: _____

### Xeljanz® (tofacitinib)

☐ 5 mg Tablet
**SIG:** _____
OTY: Refill:

### Stelara® (ustekinumab)

PFS: ☐ 1 x 45mg/0.5mL ☐ 1 x 90mg/mL
☐ Inject 45mg SQ on Day 1 (<100kg)
☐ Inject 90mg SQ on Day 1 (>100kg)
☐ Inject 45mg SQ on Day 29 and every 12 weeks thereafter (<100kg)
☐ Inject 90mg SQ on Day 29 and every 12 weeks thereafter (>100kg)
QTY: _____ Refill: _____

### Simponi® (golimumab)

☐ 50 mg Syringe ☐ 50 mg Smartject
☐ 50 mg Vial (Aria)
**SIG:** _____
QTY: _____ Refill: _____

**Other/Notes**: _____
_____
_____
_____

**Prescriber Signature:** _____ **DAW (Dispense as Written)** ☐ Y ☐ N **Date:** _____