Rheumatology Therapies – Referring Physician Orders

Please fax completed referral form & all required documents to (843) 212-8280

Lowcountry Infectious Diseases

PATIENT DEMOGRAPHICS

Patient Name: ______________________ DOB: ______________ Phone: ______________

Address: ______________________ City/ST/Zip: ______________________

Allergies: ______________________ ☐ NKDA Weight: ________ ☐ lbs ☐ kg Height: ________ ☐ in ☐ cm

INSURANCE INFORMATION: ***Please attach copy of insurance card (front and back).***

DIAGNOSIS*

***ICD 10 Code Required**

☐ Arthropathic Psoriasis (L40.50-L40.59), ICD10 ___________

☐ Juvenile Rheumatoid Arthritis (M08.00-M08.99), ICD10 ___________

☐ Systemic Lupus Erythematosus (SLE) (M32.0-M32.9), ICD10 ___________

☐ Other: ______________________, ICD10 ___________

☐ Rheumatoid Arthritis (M05.70-M05.9, M06.00-M06.09, M06.9), ICD10 ___________

☐ Ankylosing Spondylitis (M45.0-M45.9), ICD10 ___________

INFUSION ORDERS

MEDICATION	DOSE	DIRECTIONS/DURATION
Actemra® (tocilizumab)	☐ **4mg/kg** ☐ **8mg/kg** ☐ _______ **mg (total)**	☐ Infuse IV over 1 hour every 4 weeks x 1 year
Benlysta® (belimumab)	☐ **10mg/kg** ☐ _______ **mg (total)**	☐ **INITIAL:** Infuse IV over 1 hour at Weeks 0, 2, 4, then every 4 weeks x 1 year ☐ **MAINTENANCE:** Infuse IV over 1 hour every 4 weeks x 1 year
Cimzia® (certolizumab pegol)	☐ **INITIAL:** 400mg ☐ **MAINTENANCE:** ☐ 400mg ☐ 200mg	☐ **INITIAL:** Inject 400mg SUBQ at Weeks 0, 2, 4, then every 4 weeks x 1 year ☐ **MAINTENANCE:** Inject 400mg SUBQ every 4 weeks x 1 year ☐ **MAINTENANCE:** Inject 200mg SUBQ every 2 weeks x 1 year
Infliximab and biosimilars Brands available: ☐ Avsola® ☐ Remicade® ☐ Inflectra® ☐ Renflexis®	☐ _______ **mg/kg** ☐ _______ **mg (total)**	☐ **INITIAL:** Infuse IV over 2 hours at Weeks 0, 2, 6, then every _______ weeks x 1 year ☐ **MAINTENANCE:** Infuse IV over 2 hours every _______ weeks x 1 year
Orencia® (abatacept)	☐ **<60kg:** 500mg ☐ **60-100kg:** 750mg ☐ **>100kg:** 1000mg	☐ **INITIAL:** Infuse IV over 30 minutes at Weeks 0, 2, 4, then every 4 weeks x 1 year ☐ **MAINTENANCE:** Infuse IV over 30 minutes every 4 weeks x 1 year
Saphnelo® (anifrolumab)	300mg	☐ Infuse IV over 30 minutes every 4 weeks x 1 year
Simponi Aria® (golimumab)	☐ **2mg/kg** ☐ _______ **mg (total)**	☐ **INITIAL:** Infuse IV over 30 minutes at Weeks 0, 4, then every 8 weeks x 1 year ☐ **MAINTENANCE:** Infuse IV over 30 minutes every 8 weeks x 1 year
Rituximab and biosimilars Brands available: ☐ Riabni® ☐ Ruxience® ☐ Rituxan® ☐ Truxima®	1000mg	☐ Infuse IV over _____ hours on Days 1 and 15 every _____ weeks x 1 year
OTHER:		

Is patient currently receiving therapy above from another facility? ☐ **NO** ☐ **YES**

If yes, Facility Name: ______________________ Date of last treatment: ____________ Date of next treatment: ____________

OTHER ORDERS

LAB ORDERS: Labs to be drawn by: ☐ Infusion Center ☐ Referring Physician

☐ No labs ordered at this time

☐ CBC q __________ ☐ CMP q __________ ☐ CRP q __________ ☐ ESR q __________ ☐ LFTs q __________ ☐ Other: __________

PRE-MEDICATION ORDERS:

☐ No premeds ordered at this time

☐ Acetaminophen 650mg PO

☐ Other: ______________________

☐ Diphenhydramine 25mg PO

☐ Methylprednisolone 40mg IVP -OR- ☐ Hydrocortisone 100mg IV

REFERRING PHYSICIAN INFORMATION

Physician Signature: ______________________ Date: ______________

Physician Name: ______________ Provider NPI: ______________ Specialty: ______________

Address: ______________________ City/ST/Zip: ______________________

Contact Person: ______________ Phone #: ______________ Fax #: ______________

Email Where Follow Up Documentation Should Be Sent: ______________________

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Lowcountryid.com

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Patient Name: ____ DOB: __________________

REQUIRED CLINICAL DOCUMENTATION

Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis.

☐ **See Attached Medical Records**

Test Results (required)

- TB screening for Actemra, Cimzia, infliximab biosimilars, Orencia, and Simponi Aria (submit results from within 12 months to start therapy and annually to continue therapy)
  - Annual TB screening to be done by**:** ☐ Infusion Center ☐ Referring Physician
- Hepatitis B Screening for Actemra, Cimzia, infliximab biosimilars, Orencia, Simponi Aria, and Rituxan (submit results to start therapy)

Diagnostic Test Results (please attach copy for all items checked)

For SLE:

☐ Autoantibody test (ANA, anti-dsDNA)

Prior Failed Therapies (including DMARDs, immunosuppressants, and biologics)

Medication Failed: ______________________ Dates of Treatment: ______________________ Reason for D/C: ______________________

Medication Failed: ______________________ Dates of Treatment: ______________________ Reason for D/C: ______________________

Medication Failed: ______________________ Dates of Treatment: ______________________ Reason for D/C: ______________________

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