Rheumatology Infusion

Referral Form

Email: intake@infuseoneohio.com
Fax: (614) 929-7199

INFUSE ONE OHIO

PLEASE ATTACH INSURANCE CARDS - FRONT AND BACK

☐ Dublin, OH ☐ Lancaster, OH

PATIENT INFORMATION

Last Name, First Name | **Date of Birth** | **Gender** ☐ M ☐ F

Address | **City, State, ZIP** | **Phone**

REFERRING PROVIDER INFORMATION

Referring Practice | **Practice Address / City / State / ZIP**

Prescriber Name | **Prescriber NPI** | **Nurse / Key Contact** | **Phone**

Fax | **Email**

INSURANCE INFORMATION

PRIMARY **Insurance Plan** | **Policy #** | **Plan ID** | **SECONDARY** **Insurance Plan**

Secondary Policy # | **Secondary Plan ID**

DIAGNOSIS & CLINICAL INFORMATION

Attach clinical/progress notes, labs, tests, and supporting diagnosis

☐ Rheumatoid Arthritis ☐ Lupus Erythematosus

☐ Ankylosing Spondylitis ☐ Psoriatic Arthritis

☐ Gout ☐ Other **ICD-10**

Currently received and/or prior failed therapies

Length of treatment | **Reason for discontinuation**

TB/PPD Test ☐ Positive ☐ Negative **Date**

Hepatitis B ☐ Positive ☐ Negative **Date**

☑ Use Infuse One Ohio hypersensitivity protocol

☐ Allergies

☐ NKDA

Height | **Weight**

Site of Care ☐ Home ☐ AIC ☐ Other

PRESCRIPTION INFORMATION

MEDICATION	DOSE / STRENGTH	DIRECTIONS	REFILLS
☐ Remicade (infliximab)	☐ 100 mg vial	☐ INITIAL: Infuse _____ mg/kg IV over 2-3 hours at weeks 0, 2, 6, then every 8 weeks ☐ MAINTENANCE: Infuse _____ mg/kg IV over 2-3 hours every _____	
☐ Stelara (ustekinumab)	☐ 45 mg vial	☐ INITIAL: 45 mg SQ initially, 4 weeks later, then every 12 weeks ☐ MAINTENANCE: 45 mg SQ every 12 weeks ☐ INITIAL: 90 mg SQ initially, 4 weeks later, then every 12 weeks ☐ MAINTENANCE: 90 mg SQ every 12 weeks	
☐ Simponi Aria (golimumab)	☐ 50 mg vial	☐ INITIAL: 2 mg/kg IV at weeks 0 and 4, then every 8 weeks ☐ MAINTENANCE: 2 mg/kg IV every 8 weeks	
☐ Cimzia (certolizumab)	☐ 200 mg vial	☐ INITIAL: 400 mg SQ at weeks 0, 2, and 4 ☐ MAINTENANCE: 200 mg SQ every 2 weeks ☐ MAINTENANCE: 400 mg SQ every 4 weeks	
☐ Orencia (abatacept)	☐ 250 mg vial	☐ INITIAL: _____ mg IV ☐ Every 4 weeks ☐ 0, 2, 4 weeks, then every 4 weeks	
☐ Krystexxa (pegloticase)	☐ 8 mg	Infuse 8 mg IV over 2 hours every 2 weeks	

PRE-MEDICATION & OTHER MEDICATIONS

☐ Acetaminophen _____ mg PO prior to infusion

☐ Diphenhydramine _____ mg ☐ PO ☐ IV ☐ ☐

☐ Methylprednisolone _____ mg IV over _____ minutes

☐ Other

Infusion supplies and anaphylaxis kit per protocol.

FLUSH: NaCl 0.9% 10 mL before and after infusion.

AUTHORIZATION, SIGNATURE & REQUIRED ATTACHMENTS

I authorize Infuse One Ohio to initiate required insurance prior authorization for this prescription and future refills. I may revoke this designation at any time by written notice.

Physician Signature | **Date**

☐ Patient demographics

☐ Medical insurance card - front/back

☐ Pharmacy card - front/back, if available

☐ Most recent chart notes, diagnostic testing, and labs

☐ Proof of concurrent treatment with other biologics