Rheumatology
Referral Form

☐ Dublin, OH
☐ Lancaster, OH

INFUSE ONE OHIO

Please Attach Copy of Insurance Cards (Front & Back)

Last Name, First Name: _____

Date of Birth: _____ Gender: ☐ M ☐ F ☐ Other

Address: _____

City, State, Zip: _____

Phone: _____

Referring Practice: _____

Practice Address: _____

City, State, Zip: _____

Prescriber Name: _____

Prescriber NPI: _____

Nurse/Key Contact: _____

Phone: _____

Fax: _____

Email: _____

Insurance Information

Insurance Plan: _____

Policy#: _____ Plan ID: _____

Insurance Plan: _____

Policy#: _____ Plan ID: _____

Diagnosis & Clinical Information

☐ Rheumatoid Arthritis ☐ Lupus Erythematosus ☐ Gout
☐ Ankylosing Spondylitis ☐ Arthritic Psoriasis
☐ Other: _____
ICD-10: _____

☑ Center will use Hypersensitivity protocol established by Infuse One Ohio

Currently received and/or prior filed therapies: _____

Length of treatment: _____

Reason for discontinuation: _____

Please attached Clinical/Progress Notes, Labs, Tests, Supporting Primary Diagnosis**

TB/PPD Test: ☐ Positive ☐ Negative Date: _____
Hep. B: ☐ Positive ☐ Negative Date: _____
☐ Allergies _____

☐ NKDA
Height: _____ Weight: _____
Site of Care: ☐ Home ☐ AIC ☐ Other _____

Prescription Information

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

Pre-medication & other medications * Infusion supplies as per protocol * Anaphylaxis kit as per protocol	☐ Acetaminophen ☐ Diphenhydramine ☐ Methylprednisolone_____mg ☐ Other	mg PO prior to infusion mg ☐ PO ☐ IV IV over _____ min.	**Flush Protocol** * NaCl 0.9% 10ml * Before & after infusion

I authorize Infuse One Ohio and its representatives to initiate any insurance prior authorization process that is required for this prescription and for any future refills of the same prescription for the patient listed above which I order. I understand that I can revoke this designation at any time by providing written notice to Infuse One.

Physician Signature: _____

Date: _____

Fax: 614-929-7199
Phone: 614-929-3349
Email:
intake@infuseoneohio.com

Please be sure to attach all of the following:

- Patient demographics
- Patient medical insurance card copied front and back
- Patient pharmacy card copied front and back (if they have one)
- Most recent chart notes, diagnostic testings, and labs.
- Proof of patient being concurrently treated with any other biologics