☐ Home Infusion ☐ Alternate Site of Care

RA & INFLAMMATION REFERRAL FORM (MEDICATIONS J-Z) *(PAGE 1 OF 2)*

vitalcare of SOUTH DALLAS *NPI #: 1871219683*
TEL: 945-212-3707 **FAX:** 866-790-3580

Patient Name _____ SS#_____ DOB _____ ☐ Male ☐ Female
Street Address _____ Apt# _____ City _____ State _____ Zip _____
Daytime Tel _____ Cell _____ Email _____ Height _____ Weight _____ BSA _____
Ship to Patient at ☐ Home ☐ Work **OR** Patient will pick up at ☐ Physician Office Local Pharmacy Phone_____
Allergies _____ Comorbidities _____
Current Medications (if necessary, please fax a complete list) _____

PRACTICE NAME	ADDRESS	PHONE	PRIMARY CONTACT

PRESCRIBER INFORMATION (PLEASE INCLUDE PHYSICIAN NAME AND NPI#)

☐ _____ #_____ ☐ _____ #_____ ☐ _____ #_____
☐ _____ #_____ ☐ _____ #_____ ☐ _____ #_____
☐ _____ #_____ ☐ _____ #_____ ☐ _____ #_____

Insured's Name _____ Relation to Patient _____
Eligible for Medicare ☐ Yes ☐ No If yes, Medicare# _____ Prescription Card ☐ Yes ☐ No If Yes, Carrier _____
Tel _____ Fax _____ Policy/Group# _____
Bin# _____ Pcn# _____ RXID# _____ RX Group# _____

ICD-10 Diagnosis ☐ _____ PPD (TB Test)_____ Chest X-ray _____
Date of Labs_____ Rheumatoid Factor Positive _____ Total Swollen Joints _____

☐ To my knowledge, patient has not previously been treated with a biologic/systemic agent for the diagnosed condition.

If previously treated:

Is there a contraindication/intolerance/allergy to Cosentyx, Enbrel, Humira, Otezla, Remicade, Stelara, other biologic/systemic treatment?
☐ Methotrexate ☐ Cosentyx ☐ Enbrel ☐ Humira ☐ Otezla ☐ Remicade ☐ Stelara ☐ Other _____ ☐ No

Is there documented failure of adequate trial on any of these medications?
☐ Methotrexate ☐ Cosentyx ☐ Enbrel ☐ Humira ☐ Otezla ☐ Remicade ☐ Stelara ☐ Other _____ ☐ No

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

☐ **KEVZARA®** PFS ☐ 200 mg/1.14 mL ☐ 150 mg/1.14 mL
SIG: Inject 1 prefilled syringe subcutaneously every other week QTY: 2 Refills: ____

☐ **KINERET® 100mg/0.67ml solution**
☐ SIG: Inject 100mg subcutaneously every day QTY: ____ Refills: ____
☐ Other _____ QTY: ____ Refills: ____

☐ **OLUMIANT 2mg**
SIG: Take 2 mg PO once daily with or without food QTY: 30 Refills: ____
**monotherapy or in combination with methotrexate or other disease-modifying antirheumatic drug*

☐ **ORENCIA® 250mg vial** Patient wt (kg) _____
☐ Patient weight < 60kg: Loading Dose: 500mg (2 vials) IV x 1 dose
☐ Patient weight 60kg to 100kg: Loading Dose: 750mg (3 vials) IV x 1 dose
☐ Patient weight >100kg: Loading Dose: 1000mg (4 vials) IV x 1 dose then administer the first 125mg subcutaneous weekly within 24hrs of IV dose
☐ Begin subcutaneous injections **without** IV loading dose
**please complete IV infusion section*

☐ **ORENCIA®** ClickJect Pen ☐ 125mg/ml Patient wt (kg) _____
PFS ☐ 50mg/0.4mL ☐ 87.5mg/0.7ml ☐ 125 mg/mL
☐ SIG: Inject 125mg subcutaneously once weekly QTY: 4 Refills:____
Juvenile Arthritis QTY: 4 Refills:_____ Patient wt (kg) _____
☐ Patient weight 10kg to <25kg: inject 50mg subcutaneously once weekly
☐ Patient weight 25kg to <50kg: inject 87.5mg subcutaneously once weekly
☐ Patient weight ≥50kg: inject 125mg subcutaneously once weekly

☐ **OTEZLA®** ☐ 28 day Titration Starter Pack
☐ Take as directed **These directions can only be selected for the Titration Starter Pack** QTY: 55
☐ Take 30 mg by mouth twice daily QTY: 60 Refills: ____
☐ Other _____ QTY: ____ Refills: ____
if the patient requires renal dose adjust for the once daily dosing

☐ **REMICADE 100 mg vial** ☐ MD Office Infusion ☐ Home Infusion
Infusion Supplies: ☐ YES ☐ NO Patient wt (kg) _____
☐ **Starting Dose:** ___mg/kg ___mg IV on week 0, week 2 & week 6 then,
☐ **Maintenance Dose:** ___mg/kg ____ mg IV every 8 weeks
☐ Other _____ QTY: ____ Refills: ____
**please complete IV infusion section*

☐ **RINVOQ 15mg extended release tablets**
SIG: Take one tablet (15mg) by mouth once daily with or without food
QTY: 30 Refills: ____

☐ **RITUXAN 10mg/ml** ☐ 500mg/50ml vial ☐ 100mg/10ml vial
☐ **Start Dose:** 1000mg IV every 2 weeks x 2 doses in combination with methotrexate QTY: 4
☐ **Maintenance:** Administer subsequent doses every 24 weeks or based on clinical evaluation, but not sooner than every 16 weeks
QTY: ____ (vials) Refills: ____

☐ **SIMPONI® 50mg/0.5mL** ☐ SmartJect™ ☐ PFS
SIG: Inject 50mg subcutaneously once per month QTY: 1 Refills: ____

☐ **SIMPONI ARIA® 50mg/4mL vial** Patient wt (kg) _____
☐ **Start Dose:**Infuse ____mg (2mg/kg) IV over 30 mins at weeks 0 and 4, then begin maintenance dose every 8 weeks thereafter
QTY: ____ (vials)
☐ **Maintenance:** Infuse ____mg (2mg/kg) IV over 30 minutes every 8 weeks
QTY: ____ (vials) Refills: ____
**please complete IV infusion section*

☐ **TALTZ 80mg/mL** ☐ Autoinjector ☐ PFS
☐ **Start Dose:** Inject 160 mg (2-80mg injections) subcutaneously at week 0
QTY: 2 Refills: 0
☐ **Maintenance:** Inject 80mg subcutaneously every 4 weeks
QTY: 1 Refills: ____

☐ **XELJANZ® 5mg tablet**
SIG: Take 5mg tablet by mouth twice daily QTY: 60 Refills: ____
☐ **XELJANZ XR® 11mg tablet**
SIG: Take 11mg tablet by mouth once daily QTY: 30 Refills: ____

☐ **OTHER** _____
SIG: _____ QTY: ____ Refills: ____

COMPLETE PAGE 2 FOR IV INFUSION CLINICAL INFORMATION

Prescriber's Signature _____ *(Signature required. NO STAMPS)* **AND** *Hand write: brand medically necessary, if needed* **Date**_____
Prescriber's Email_____

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Patient Name _____ DOB _____

IV INFUSION

MEDICATION ORDERS

☐ Dilute with Normal Saline according to manufacturer guidelines
Administer Rate: ☐ per manufacturer guidelines, as tolerated ☐ Other (MD to specify) _____

PRE-MEDICATIONS *Pre-Medicate: 30 minutes prior*

The quantity and refills of pre-medications will be appropriate based on primary therapy requirements.

☐ Diphenhydramine _____ mg orally ☐ Diphenhydramine _____ mg IVP ☐ Acetaminophen _____ mg orally
☐ Hydrocortisone _____ mg IV push ☐ pre ☐ halfway ☐ upon completion
☐ Other: _____ ☐ Other: _____

IV ACCESS/FLUSH/SUPPLY ORDERS

IV Access: ☐ Peripheral ☐ PICC ☐ Port ☐ Central line (Borviac/Hickman)

Flush Protocol:

The quantity and refills of flushing protocol medications will be appropriate based on primary therapy requirements.

☐ Sodium Chloride 0.9% 5-10 ml IV using SASH method and as needed for catheter patency
☐ Heparin flush _____ units/ml flush with 5ml using SASH method as need for catheter patency

Pump and Ancillary Supplies: as required for therapy and diagnosis

ANAPHYLAXIS/FLUSH/SUPPLY ORDERS *(Supplies will be provided as per therapy requirements)*

Anaplylaxis Kit: ☐ Adult ☐ Pediatric (administer according to company policy and procedure)

Orders:

1. Stop infusion
2. Call 911 and prescribing physician
3. Administer medications below as per protocol

- **Diphenhydramine**: QTY: 2 x 50 mg/ml vials and 2- 25 mg oral dosage form Refills: _____
  Adults and children weight greater than 66 lbs or 30 kg
  For mild or moderate reaction: Administer 50 mg orally, IM or slow IV push
  For severe reaction: Administer 50 mg slow IV push or IM
  Children weight 33-66 lbs or 15-30 kg
  For mild or moderate reactions: Administer 25 mg orally, IM or slow IV push
  For severe reaction: Administer 25 mg IM or slow IV push
  Children weight < 33 lbs or 15 kg
  For mild or moderate reaction: Administer 12.5 mg orally, IM or slow IV push
  For severe reaction: Administer 12.5 mg IM or slow IV push
- **Epinephrine** QTY: 1 ampule Refills: _____
  Adults and children weight greater than 66 lbs/30kg: Administer 0.3 mg/0.3 ml subcutaneously or IM
  Children weight 33-66 lbs or 15-30 kg: Administer 0.15 mg/0.15 ml subcutaneously or IM
  Children weight <33 lbs or 15 kg: Administer ____mg (0.01 mg/kg or 0.01 ml/kg) subcutaneously or IM
  Other _____ SIG _____ QTY: _____ Refills: _____

NURSING ORDERS

☐ Provide skilled nursing care to complete therapy.
☐ Administration
☐ Provide education regarding medication, disease state, adverse drug reactions, and administration. Observe for response to therapy.
☐ Maintain IV Access according to company policy and procedure.
☐ Clinical Monitoring where appropriate.

COMMENTS _____

_____

_____

Prescriber's Signature _____ *(Signature required. NO STAMPS)* **AND** *Hand write: brand medically necessary, if needed* **Date** _____

Prescriber's Email _____