HOME INFUSION GROUP

RHEUMATOLOGY REFERRAL FORM

FAX: 718-676-9111
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PATIENT INFORMATION

Patient Name: ______________________________
Home Address: ______________________________
City, State, Zip: ______________________________
Home Phone: ______________________________
Cell Phone: ______________________________
SS: ______________________________
Date of Birth: ________________ Gender: ☐ Male ☐ Female
Contact Person & #: ______________________________

PRESCRIBER INFORMATION

Prescriber Name: ______________________________
Home Address: ______________________________
City, State, Zip: ______________________________
Phone: ______________________________
Fax: ______________________________
DEA: ________________ License #: ________________
NPI #: ______________________________

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

Primary Insurance: ______________________ ID#: ______________ Group: __________
Secondary Insurance: ______________________ ID#: ______________ Group: __________
Prescription Card: ______________ ID#: __________ BIN: ________ PCN: ________ Group: __________

DIAGNOSIS/ ICD 10 CODE

☐ ________________ ☐ ________________
☐ ________________ ☐ ________________

PRIOR FAILED MEDICATIONS

________________ ________________
________________ ________________

PATIENT EVALUATION

Patient Weight: ____________ Kg/ Lbs. Height: ________ Inches/CM Allergies: ______________ ______________
Does pt. have any active Infection? ☐No ☐Yes **Date of** ☐negative ☐positive **TB Test**:________ Is the pt. currently on Methotrexate? ☐Yes ☐No

PRESCRIPTION INFORMATION

Medication	Dose and Strength	Directions	Quantity	Refills
☐ Actemra© (Tocilizumab)	☐ 162mg PF Syringe ☐ 20mg/ml Vial	☐ Pts < 100Kg: 162 mg SC every other week (Max=162 mg SC every week) ☐ Pts ≥ 100Kg: 162 mg SC once a week ☐ Intravenous:_______(4mg/kg) every 4 weeks, up to 8 mg/kg (Max=800mg)	____days ____weeks	
☐ Cimzia© (Certolizumab)	☐ Cimzia Starter kit ☐ 200mg Vial	☐ Induction Dose: 400mg SC on Day 1 and at weeks 2 and 4 ☐ Maintenance Dose: Inject 200 mg SC every other week ☐ Maintenance Dose: Inject 400 mg SC every 4 weeks	____days ____weeks	
☐ Enbrel© (Etanercept)	☐ 50mg Syringe ☐ 50mg Sure-click	☐ 50mg SC once a week. ☐ 50mg SC twice a week (Max duration 3 months)	____days ____weeks	
☐ Humira© (Adalimumab)	☐ 40 mg Syringe/Pen ☐ 20mg Syringe	☐ 40mg SC every other week (☐ Induction Dose: 80 mg x1, for PsA) ☐ Other:____________	____days ____weeks	
☐ Orencia© (Abatacept)	☐ 125 mg Syringe ☐ 250 mg Vials	☐ 125 mg SC once a week ☐ Induction Dose: Infuse ________mg Day 1, week 2, and week 4 ☐ Maintenance Dose: Infuse ________mg every 4 weeks	____days ____weeks	
☐ Remicade© (Infliximab)	☐ 100mg / 20 ml vial in 250 mL of 0.9% NS	☐ Induction Dose: IV at 5mg/kg (Dose =__________mg) at 0, 2 and 6 weeks ☐ Maintenance Dose: IV at 5mg/kg (Dose = ___________mg) every 8 weeks ☐ Other: ______________________	____days ____weeks	
☐ Simponi-Aria© (Golimumab)	☐ 50 mg/ml vial ☐ 100 mg/ml vial	☐ Intravenous: 2mg/kg IV at week 0, week 4 then every 8 weeks ☐ SubQ: 50 mg once a month (in combination with methotrexate)	____days ____weeks	
☐ Other				

Other Medications

PREMEDICATE: ☐ **Diphenhydramine (Benadryl)** _______ mg ☐ PO ☐ Inj. ☐ **APAP (Tylenol)** ______ mg PO ☐ Other: ______________
PRN for Anaphylactic Reaction: ☐ **Hydrocortisone 100mg** IV Push ☐ **Epinephrine 0.3mg IM** **Sodium Chloride 0.9%**: ☐ 250 ml ☐ 500 ml

☐ Sodium Chloride 0.9% **Flush** ☐3 ml ☐5 ml ☐10 ml ☐20 ml ☐30 ml ☐ Flush IV line before and after infusion
☐ Heparin Flush **10** units/ml ☐3 ml ☐5 ml ☐ Heparin Flush **100** units/ml ☐3 ml ☐ 5 ml ☐ Flush IV line after infusion

NURSING: Requires Placement ☐ PIV ☐ Midline IV Line for administration and nurse to administer infusion in home

Current IV Access: ☐PIV ☐PICC ☐Midline ☐PORT ☐OTHER _______ _____**Number of Lumens** Delivery Method: ☐ Gravity ☐ Infusion Pump
Therapy Start Date: ____________ Length of Therapy: __________Pharmacy to coordinate home health nursing visit as necessary: ☐ Yes ☐ No

By signing this form and utilizing our services, you are authorizing Home Infusion Group, Inc. and it's employees to serve as your authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber Signature: ______________________________ (required) **Date**: ______________________ (required)

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