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INFO@MEDRXINFUSION.COM
MEDRXINFUSION.COM

Date Medication Needed ______________________________

Ship to: ☐Patient ☐ Prescriber ☐Other : ____________

Rheumatology Referral Form Infusion Medications

This referral form is provided in order to best serve our patients and prescribers. Patients may choose any pharmacy of their choice.

Complete patient demographics below or otherwise provide the information requested along with this referral form. Also needed : 1) Patient insurance information (front and back of card) 2) History and physical, chart notes, laboratory results and other diagnostic tests needed to support the use of this medication 3) patient's medication history related to their current diagnosis/problem.

Patient name: ______________________ Date of birth: ________ height: ______ weight: ______

Address: ______________________ Allergies/Intolerances: ______________________

Phone number(s): ______________________ ☐ No known allergies: ______________________

Treatment Diagnosis/Problem(s): ______________________ Medications failed and reasons: ______________________

Prescriber name: ______________________ Contact person: ______________________

Office Address: ______________________

Phone number: ______________ Fax number: ______________ NPI number: ______________

☐ Actemra (tocilizumab) _____ mg/kg in NS 50 ml IV over 60 minutes every 4 weeks 4 weeks supply for ______ months
(start 4 mg/kg and increase up to max of 8 mg/kg based upon response)

☐ Benlysta (belimumab) 10 mg/kg in NS 250 ml over 1 hr Loading dose ☐ q 2 wks for 3 doses then ☐ every 4 wks 4 weeks supply for ______ months

☐ Orencia (abatacept) ______ mg dose in NS 100 ml IV over 30 minutes Loading dose ☐ weeks 0, 2 and 4 then ☐ every 4 weeks
(weight based dosing is 500 mg < 60 kg, 750 mg 60 kg – 100 kg, 1000 mg >100 kg) 4 weeks supply for ______ months

☐ Remicade (infliximab) ______ mg/kg in NS 250 ml IV over 2 hrs Loading dose ☐ weeks 0,2 and 6, then ☐ every ______ weeks
(diagnosis/condition and response dictate the dose and frequency 3 mg/kg up to 10mg/kg, every 4 to 8 weeks) 4 weeks supply for ______ months

☐ Rituxan (rituximab) 1000 mg once and repeat in 2 weeks, repeat every 24 weeks (about every 6 months) 4 weeks supply for ______ months
Dilute in NS not less than 250 ml and infusion rate varies. Requires premedication with corticosteroid : list premedications:______________________

☐ Simponi (golimumab) 2mg/kg in NS 100 ml IV over 30 minutes week 0, 4 then q8 weeks 4 weeks supply for ______months

Therapy is going to be administered ☐ physicians office ☐ infusion suite ☐ in patients home Note: supplies and diluents for physician office and infusion suite use may need to be ordered separately.

☐ Home Health care nursing is needed to infuse medication at home, which may include reconstitution and dilution of the medication according the manufacturer's or pharmacists instructions, accessing a vein for infusion intravenously, maintaining the intravenous catheter per nursing and MedRx protocol, as well as assessing the patient's response and tolerance to therapy.

Med Rx will supply the following for in home infusions: Note: First lifet ime doses generally should not be given at home. Consult with the Pharmacist to discuss: Medication requires that anaphylaxis kit (epinephrine, diphenhydramine) be on hand at home for these infusions per MedRx and nursing policy and procedure. Supplies to administer which may include an infusion pump, supplies to maintain venous access, including heparin 100 u/ml flush and sodium chloride 0.9% flush.

☐ Patient has an existing intravenous access device (catheter type) ______________ date placed ______________ and will require Home Health to maintain the intravenous catheter and MedRx to provide supplies needed

Physicians Signature:______________________ Date: ______________

IMPORTANT NOTICE: This form my contain confidential and privileged information and is only intended only for the person named herein. If you are not the named addressee, do not disseminate, distribute or copy this form or any of its contents. Please notify the sender immediately if you have received this document by mistake, then destroy this form.