

# Rheumatology Referral Form

Please send the following with clinical documentation, which includes visit, physical and history notes, plus lab results for last 3 months, to:

p: 844.575.1515 | f: 844.797.5050 | e: specialtyreferrals@soleohealth.com

**This form is not a valid prescription**

--- Please detach before submitting to a pharmacy. Cut or tear here. ---

## PATIENT INFORMATION

Patient Name		DOB	Contact Phone	
Address		City	State	Zip
Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security, last 4 digits		Weight (lb.)	Height (in.)
<input type="checkbox"/> NKDA	<input type="checkbox"/> Allergies			Date
ICD-10 code (required)		ICD-10 description		
Patient Status <input type="checkbox"/> New to Therapy <input type="checkbox"/> Continuing Therapy	TB Skin Test <input type="checkbox"/> Yes <input type="checkbox"/> No		Hepatitis B Screen <input type="checkbox"/> Yes <input type="checkbox"/> No	

## PRESCRIBER INFORMATION

Ordering Prescriber		Prescriber NPI		
Practice Name		Phone	Fax	
Practice Address		City	State	Zip

## REQUIRED DOCUMENTATION

<input type="checkbox"/> Insurance Cards	<input type="checkbox"/> History & Physical	<input type="checkbox"/> Most Recent Labs	<input type="checkbox"/> Medication List
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## RHEUMATOLOGY TREATMENT PLAN

<input type="checkbox"/> Remicade® or Biosimilar _____ Loading dose: <input type="checkbox"/> 5mg/kg <input type="checkbox"/> 7.5mg/kg <input type="checkbox"/> 10mg/kg at 0, 2 and 6 weeks, then every _____ weeks thereafter	
<input type="checkbox"/> Rituxan® or Biosimilar _____ <input type="checkbox"/> 500mg <input type="checkbox"/> 1000mg <input type="checkbox"/> Administer IV at day 1, then at day 15. Administer every _____ months thereafter	
<input type="checkbox"/> Krystexxa® Dose: 8mg/50ml Ready to Use vial • Registered nurse to infuse intravenously over no less than 120 minutes every 2 weeks • Patient will be monitored by a registered nurse 2 hours post infusion	
<input type="checkbox"/> Simponi Aria® 2mg/kg IV infusion over 30 min, then at week 4 and then every 8 weeks thereafter	
<input type="checkbox"/> Stelara® <input type="checkbox"/> 45mg subcutaneously at initial, and week 4. Followed by 45mg subcutaneously every 12 weeks after (patients < 100kg) <input type="checkbox"/> 90mg subcutaneously at initial, and week 4. Followed by 90mg subcutaneously every 12 weeks after (patients > 100kg)	
<input type="checkbox"/> Skyrizi® <input type="checkbox"/> Loading Doses - Inject 150 mg SC at weeks 0 and 4 <input type="checkbox"/> Maintenance Dose - Inject 150 mg SC every 12 weeks thereafter	<input type="checkbox"/> Tremfya® <input type="checkbox"/> Loading Doses - Inject 100 mg SC weeks 0 and 4 <input type="checkbox"/> Maintenance Dose - Inject 100 mg SC every 8 weeks thereafter
<input type="checkbox"/> Other	Include dosage, frequency and any other special instructions.
<input type="checkbox"/> Refill for 1 year	

## NURSING

Skilled RN to establish and maintain vascular access as needed, draw ordered labs, conduct patient assessments, and educate on home infusion, medication administration, self-monitoring and safety.

## PREMEDICATION

<input type="checkbox"/> Include premedication per Pharmacy's infusion protocol.
<input type="checkbox"/> Other _____

## LABORATORY ORDERS

<input type="checkbox"/> CBC every _____
<input type="checkbox"/> CMP every _____
<input type="checkbox"/> Other _____

The Pharmacy may contact the prescriber to comply with state-specific requirements. The prescriber is required to comply with any applicable state-specific prescription requirements (e.g., e-prescribing, prescription forms).

The information in this form is intended only for the person(s) or entity to which it is addressed and may contain confidential or legally protected material. If you receive this information in error, please contact the sender and destroy the document(s) promptly at the direction of the sender.