

Date Shipment Needed:	Ship To: □Patient □Prescriber
$lue{}$ Nursing needed; $lue{}$ Training needed $lue{}$ All the supplies including syringes and	I needles will be dispensed if needed.

RHEUMATOLOGY IV ROUTE REFERRAL FORM

Patent Name: DOB: Sex UM UF Weight: Dibs. Ukg. SSN Address: City: State: Zip: Energypny Contact: Phone: Pho	Phone: 1-800-275-0139 • Fa	1X: 043-972-9395								
SSN Phone: Allerges: City: State: Zip:	PATIENT INFORMATION									
Address	Patient Name:			DOB:	Sex: ☐M ☐F	Weight	t:	□lbs. □kg.		
Address	SSN:	Phone:	Allergies:		•					
Emergency Contact: Phone: Disable attach demographic information Prescriber NPL Disable attach demographic information Prescriber NPL Disable attach demographic information Prescriber NPL Disable State Lic Supervising Physicians: City State Disable State Disable State Disable Disab	Address:			Citv:	State:		Zip:			
PRESCRIBER INFORMATION Prescriber NPI: DEA: State Lic:	Emergency Contact:		Phone:	1 - 7		tach der		1		
Prescribe: Process Pro)N								
Supervision Physician Practice Name: City State: Zip:			NPI:	DEA:		State	Lic:			
Address: City: State: Zip:			1			Otato				
Phone: Fax: Key Office Contact: Phone: Phone: DIAGNOSISINFORMATION MEDICAL ASSESIMENT					State:		Zin·			
Place Class Translating reserved a Quartiferon gold. Tspot. or PPO (tuberculosis) Skin Test? Ves No Date: Results: No State Provided in Francis 100 State Provided in Francis Provid		Fax [.]		,		Phone:	L. P.			
Primary Diagnosis: DM05 9 Revenue and Anthris DL40 54: 140 98 Pointek Anthris DM05 00 Poyenticular Juvenile Revenue and Anthris DM05 00 Juvenile Idiopathic Arthris DM05 9 Anthris DM05 provides DM05 9 Anthris DM05 9				rtoy omoo oontaot.		1 110110.				
Starter Dose: 4 mg/kg	Primary Diagnosis: □M06.9 Rheumatoid Arthritis □L40.54; L40.59 Psoriatic Arthritis □M08.00 Polyarticular Juvenile Rheumatoid Arthritis □M08.00 Juvenile Idiopathic Arthritis □M45.9 Ankylosing Spondylitis □M33.20 Polmyositis □M15.0 - M15.9 Osteoarthritis □Other: □Has patient been treated previously for this condition? □Yes □No Is patient currently on therapy? □Yes □No Medications: □Is patient currently on therapy? □Yes □No If yes, how long should patient wait before starting the new medication? □Yes □No If yes, how long should patient wait before starting the new medication? □Yes □No If yes, how long should patient wait before starting the new medication? □Yes □No If yes, how long should patient wait before starting the new medication? □Yes □No If yes, how long should patient wait before starting the new medication? □Yes □No If yes, how long should patient wait before starting the new medication? □Yes □No If yes, how long should patient wait before starting the new medication? □Yes □No If yes, how long should patient wait before starting the new medication? □Yes □No If yes, how long should patient wait before starting the new medication? □Yes □No If yes, how long should patient wait before starting the new medication? □Yes □No If yes, how long should patient wait before starting the new medication? □Yes □No If yes, how long should patient wait before starting the new medication? □Yes □No If yes, how long should patient wait before starting the new medication? □Yes □No If yes, how long should patient wait before starting the new medication? □Yes □No If yes, how long should patient wait before starting the new medication? □Yes □No If yes, how long should patient wait before starting the new medication? □Yes □No If yes, how long should patient wait before starting the new medication? □Yes □No If yes, how long should patient wait before starting the new medication? □Yes □No If yes, how long should patient wait before starting the new medication? □Yes □No If yes, how long should patient wait before starting the new m									
The the case of anaphylazis, Inj. In anterolateral thigh area #2 IVIG	□Starter Dose: 4 mg/kg □Maintenance Dose: 8 mg/	mg IV every 4 weeks, infusion of	ver 60 minutes (inf			(QTY: <u>QS</u>	Refills:		
Home Infusion (please ask your local Palmetto Specialty Pharm representative) QTY:_QS Refills:			s than 30 kg, 0.15	mg IM x 1, may repeat		(QTY:	Refills:		
Grid Home Infusion (please ask your local Palmetto Specially Pharm representative) GTY: GS Refills: Dosage: GTY: GS Refills: Dosage: GTY: GS Refills: Dosage: GTY: GS Refills: GTY: Jox (2 syringes) Refills: GTY: Jox (3 syringes) Refills:		ral thigh area #2								
DMD's office infusion Infusion supplies needed OTY: QS Refills: Dosage: OTY: QS Refills: Dosage: OTY: 1 box (2 syringes) Refills: Carroll in The Circle Program OTY: 1 box (2 syringes) Refills: Orencia® IV 250 mg Vial for IV *Dosage based on patient's weight DMD's office infusion Infusion supplies needed DEnroll in The Circle Program DAdminister 125mg by subcutaneous injection once weekly with or without an intravenous loading dose. OTY: Refills: DFor patients initiating therapy with an IV loading dose, administer a single IV infusion (per Kg categories above), followed by the first 125 mg Subcutaneous injection given within a day of the IV infusion OPencia® ClickJet Autoinjector DAdminister 125mg by subcutaneous injection once weekly with or without an intravenous loading dose. OTY: Refills: DFor patients initiating therapy with an IV loading dose, administer a single IV infusion (per Kg categories above), followed by the first 125 mg subcutaneous injection given within a day of the IV infusion DFOR patients initiating therapy with an IV loading dose, administer a single IV infusion (per Kg categories above), followed by the first 125 mg subcutaneous injection given within a day of the IV infusion DRMICAGE NOTE: Refills: OTY: OTY: Refills: OTY:	-									
Dosage:QTY: QS	☐Home Infusion (please as	k your local Palmetto Specialty Pharm repres	entative)				·			
□Kevzara® 200 mg/1.14mL Prefilled Syringe, 200 mg SQ every 2 weeks □TY: 1 box (2 syringes) Refills: □Orencia® IV 250 mg Vial for IV *Dosage based on patient's weight □MD's office infusion □Infusion supplies needed □Enroll in The Circle Program □Administer 125mg by subcutaneous injection once weekly with or without an intravenous loading dose. QTY:		itusion supplies needed								
□ Orencia® IV 250 mg Vial for IV *Dosage based on patient's weight □ MD's office infusion □ Infusion supplies needed □ Administer 125mg by subcutaneous injection once weekly with or without an intravenous loading dose. □ For patients initiating therapy with an IV loading dose, administer a single IV infusion (per Kg categories above), followed by the first 125 mg subcutaneous injection given within a day of the IV infusion □ Orencia® ClickJet Autoinjector □ Administer 125mg by subcutaneous injection once weekly with or without an intravenous loading dose. □ For patients initiating therapy with an IV loading dose, administer a single IV infusion (per Kg categories above), followed by the first 125 mg subcutaneous injection given within a day of the IV infusion □ Remicade® 100 mg Vial □ MD's office infusion □ Infusion supplies needed □ Starter Dose: □ mg/kg □ mg IV on: Week 0, 2, 6, then follow maintenance dosing instructions □ Refills: □ Refills: □ Maintenance Dose: □ mg/kg □ mg IV every weeks for □ infusions □ Infusion as Directed (MD's Office Infusion) □ Day 1 □ Day 15 (will dispense available vial size) □ Other: □ QTY: QS Refills: □ Starting Dose: 2 mg/kg □ mg IV at Weeks 0 and 4, infusion over 30 minutes □ Maintenance Dose: □ mg/kg □ mg IV at Weeks 0 and 4, infusion over 30 minutes □ Maintenance Dose: 2 mg/kg □ mg IV every 8 weeks, infusion over 30 minutes □ Maintenance Dose: 2 mg/kg □ mg IV every 8 weeks, infusion over 30 minutes □ Maintenance Dose: 2 mg/kg □ mg IV every 8 weeks, infusion over 30 minutes □ Maintenance Dose: 2 mg/kg □ mg IV every 8 weeks, infusion over 30 minutes	□Dosage:							Refills:		
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□For patients initiating therapy with an IV loading dose, administer a single IV infusion (per Kg categories above), followed by the first 125 mg subcutaneous injection given within a day of the IV infusion □Orencia® ClickJet Autoinjector □Administer 125mg by subcutaneous injection once weekly with or without an intravenous loading dose. □For patients initiating therapy with an IV loading dose, administer a single IV infusion (per Kg categories above), followed by the first 125 mg subcutaneous injection given within a day of the IV infusion □Remicade® 100 mg Vial □MD's office infusion □Infusion supplies needed □Starter Dose:mg/kgmg IV on: Week 0, 2, 6, then follow maintenance dosing instructions □Rituxan® 1000 mg IV Infusion as Directed (MD's Office Infusion) □Day 1 □Day 15 (will dispense available vial size) □Other:mg IV everyweeks forinfusions	□Orencia® IV 250 mg Vial for IV	/ *Dosage based on patient's weight ☐MD'	s office infusion 🖵	Infusion supplies needed		Į	□Enroll in The Circle Pro			
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□Administer 125mg by subcutaneous injection once weekly with or without an intravenous loading dose. QTY:						(QTY:	Refills:		
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□Maintenance Dose: mg/kg mg IV every weeks for infusions QTY: Refills: □Rituxan® 1000 mg IV Infusion as Directed (MD's Office Infusion) □Enroll in RISE Program □Day 1 □Day 15 (will dispense available vial size) □Other: QTY: QS Refills: □Stimponi® Aria 50 mg/4 mL Single-use Vial □Enroll in RISE Program □Starting Dose: 2 mg/kg mg IV at Weeks 0 and 4, infusion over 30 minutes QTY: QS Refills: □Maintenance Dose: 2 mg/kg mg IV every 8 weeks, infusion over 30 minutes QTY: QS Refills: □Alternate Dose: QTY: QS Refills: QTY: QS Refills: QTY: QS	□Remicade® 100 mg Vial □M	D's office infusion Infusion supplies need	led			Į	□Enroll in AccessOne P	rogram		
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						(QTY: <u>QS</u>	Refills:		
	□ Other □Dosage:					(QTY:_	Refills:		

Prescriber's Signature:_ ☐ DAW (Dispense as Written) Date: Prescriber certifies that this referral form contains an original signature and is signed by the treating prescriber. NO STAMPED SIGNATURES WILL BE ACCEPTED. Where required by law, send electronic prescription or on official state prescription blank. In the event requested agent is not available through Palmetto Specialty Pharm, this prescription shall be forwarded to an eligible pharmacy.

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