

# Rheumatology Therapies

Referring Physician Orders Rev. 03.2025

Please fax completed referral form & all required documents to 208-595-4427



## PATIENT DEMOGRAPHICS

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ City/ST/Zip: \_\_\_\_\_  
Allergies: \_\_\_\_\_ ☐ NKDA Weight: \_\_\_\_\_ ☐ lbs ☐ kg Height: \_\_\_\_\_ ☐ in ☐ cm

**INSURANCE INFORMATION: Please attach copy of insurance card (front and back).**

## DIAGNOSIS\*

**\*ICD 10 Code  
Required**

- ☐ Arthropathic Psoriasis (L40.50-L40.59), ICD10 \_\_\_\_\_ ☐ Rheumatoid Arthritis (M05.70-M05.9, M06.00-M06.09, M06.9), ICD10 \_\_\_\_\_  
☐ Juvenile Rheumatoid Arthritis (M08.00-M08.99), ICD10 \_\_\_\_\_ ☐ Ankylosing Spondylitis (M45.0-M45.9), ICD10 \_\_\_\_\_  
☐ Systemic Lupus Erythematosus (M32.0-M32.9), ICD10 \_\_\_\_\_ ☐ Other: \_\_\_\_\_, ICD10 \_\_\_\_\_

## INFUSION ORDERS

MEDICATION	DOSE	DIRECTIONS/DURATION
Benlysta® (belimumab)	<input type="checkbox"/> _____ mg (10mg/kg)	<input type="checkbox"/> <b>INITIAL:</b> Infuse IV over 1 hour at Weeks 0, 2, 4, then every 4 weeks x 1 year <input type="checkbox"/> <b>MAINTENANCE:</b> Infuse IV over 1 hour every 4 weeks x 1 year
Cimzia® (certolizumab pegol)	<input type="checkbox"/> <b>INITIAL:</b> 400mg <input type="checkbox"/> <b>MAINTENANCE:</b> <input type="checkbox"/> 400mg <input type="checkbox"/> 200mg	<input type="checkbox"/> <b>INITIAL:</b> Inject 400mg SUBQ at Weeks 0, 2, 4, then every 4 weeks x 1 year <input type="checkbox"/> <b>MAINTENANCE:</b> Inject 400mg SUBQ every 4 weeks x 1 year <input type="checkbox"/> <b>MAINTENANCE:</b> Inject 200mg SUBQ every 2 weeks x 1 year
Cosentyx® (secukinumab)	<input type="checkbox"/> <b>INITIAL:</b> _____ mg (6mg/kg) <input type="checkbox"/> <b>MAINTENANCE:</b> _____ mg (1.75mg/kg; MAXIMUM = 300mg)	<input type="checkbox"/> <b>INITIAL:</b> Infuse IV over 30 minutes x 1 dose <input type="checkbox"/> <b>MAINTENANCE:</b> Infuse IV over 30 minutes every 4 weeks x 1 year
Ilumya® (tildrakizumab)	100mg	<input type="checkbox"/> <b>INITIAL:</b> Inject SubQ at Weeks 0 and 4, then every 12 weeks x 1 year <input type="checkbox"/> <b>MAINTENANCE:</b> Inject SubQ at every 12 weeks x 1 year
Infliximab and biosimilars Brands available: <input type="checkbox"/> Avsola® <input type="checkbox"/> Remicade® <input type="checkbox"/> Inflectra® <input type="checkbox"/> Renflexis®	<input type="checkbox"/> _____ mg (3 mg/kg) <input type="checkbox"/> _____ mg (5 mg/kg) <input type="checkbox"/> _____ mg (____ mg/kg)	<input type="checkbox"/> <b>INITIAL:</b> Infuse IV over 2 hours at Weeks 0, 2, 6, then every _____ weeks x 1 year <input type="checkbox"/> <b>MAINTENANCE:</b> Infuse IV over 2 hours every _____ weeks x 1 year
Orencia® (abatacept)	<input type="checkbox"/> <b>&lt;60kg:</b> 500mg <input type="checkbox"/> <b>60-100kg:</b> 750mg <input type="checkbox"/> <b>&gt;100kg:</b> 1000mg	<input type="checkbox"/> <b>INITIAL:</b> Infuse IV over 30 minutes at Weeks 0, 2, 4, then every 4 weeks x 1 year <input type="checkbox"/> <b>MAINTENANCE:</b> Infuse IV over 30 minutes every 4 weeks x 1 year
Saphnelo® (anifrolumab)	300mg	<input type="checkbox"/> Infuse IV over 30 minutes every 4 weeks x 1 year
Simponi Aria® (golimumab)	<input type="checkbox"/> _____ mg (2mg/kg)	<input type="checkbox"/> <b>INITIAL:</b> Infuse IV over 30 minutes at Weeks 0, 4, then every 8 weeks x 1 year <input type="checkbox"/> <b>MAINTENANCE:</b> Infuse IV over 30 minutes every 8 weeks x 1 year
Tocilizumab and biosimilars Brands available: <input type="checkbox"/> Actemra® <input type="checkbox"/> Tofidence® <input type="checkbox"/> Tyenne®	<input type="checkbox"/> _____ mg (4mg/kg) <input type="checkbox"/> _____ mg (8mg/kg)	<input type="checkbox"/> Infuse IV over 1 hour every 4 weeks x 1 year
Rituximab and biosimilars Brands available: <input type="checkbox"/> Riabni® <input type="checkbox"/> Ruxience® <input type="checkbox"/> Rituxan® <input type="checkbox"/> Truxima®	<input type="checkbox"/> 1000mg <input type="checkbox"/> _____ mg	<input type="checkbox"/> Infuse IV over _____ hours on Days 1 and 15 every _____ weeks x 1 year <input type="checkbox"/> Other: _____

**Is patient currently receiving therapy above from another facility?** ☐ NO ☐ YES

If yes, Facility Name: \_\_\_\_\_ Date of last treatment: \_\_\_\_\_ Date of next treatment: \_\_\_\_\_

## OTHER ORDERS

**LAB ORDERS:** Labs to be drawn by: ☐ Infusion Center ☐ Referring Physician  
☐ No labs ordered at this time  
☐ CBC q \_\_\_\_\_ ☐ CMP q \_\_\_\_\_ ☐ CRP q \_\_\_\_\_ ☐ ESR q \_\_\_\_\_ ☐ LFTs q \_\_\_\_\_ ☐ Other: \_\_\_\_\_

### PRE-MEDICATION ORDERS:

- ☐ No premeds ordered at this time ☐ Diphenhydramine 25mg PO  
☐ Acetaminophen 650mg PO ☐ Methylprednisolone 40mg IVP -OR- ☐ Hydrocortisone 100mg IV  
☐ Other: \_\_\_\_\_

## REFERRING PHYSICIAN INFORMATION

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Physician Name: \_\_\_\_\_ Provider NPI: \_\_\_\_\_ Specialty: \_\_\_\_\_  
Address: \_\_\_\_\_ City/ST/Zip: \_\_\_\_\_  
Contact Person: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_  
Email Where Follow Up Documentation Should Be Sent: \_\_\_\_\_

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## REQUIRED CLINICAL DOCUMENTATION

**Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis.**

### Test Results (required)

- TB screening for Actemra, Cimzia, Cosentyx, infliximab biosimilars, Orencia, and Simponi Aria (submit results from within 12 months to start therapy and annually to continue therapy)
  - Annual TB screening to be done by: ☐ Infusion Center ☐ Referring Physician
- Hepatitis B Screening for Cimzia, infliximab biosimilars, Orencia, Simponi Aria, tocilizumab biosimilars and Rituxan (submit results to start therapy)

### Diagnostic Test Results (please attach copy for all items checked)

For SLE:

- ☐ Autoantibody test (ANA, anti-dsDNA)

### Prior Failed Therapies (including DMARDs, immunosuppressants, and biologics)

Medication Failed: \_\_\_\_\_ Dates of Treatment: \_\_\_\_\_ Reason for D/C: \_\_\_\_\_

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