Rheumatology Therapies

Referring Physician Orders Rev. 3/8/2023

Please fax completed referral form & all required documents to 770-618-9617

CPS | INFUSION

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 _____

☐ Dermatopolymyositis (M33.10-M33.99), ICD10 _____

☐ Polymyositis (M33.20-M33.29), ICD10 _____

☐ Systemic Lupus Erythematosus (M32.0-M32.9), 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 _____

☐ Other: _____, ICD10 _____

INFUSION ORDERS

MEDICATION	DOSE	DIRECTIONS/DURATION
Actemra® (tocilizumab)	☐ _____ mg (4mg/kg) ☐ _____ mg (8mg/kg)	☐ Infuse IV over 1 hour every 4 weeks x 1 year
Benlysta® (belimumab)	☐ _____ mg (10mg/kg)	☐ **INITIAL:** Infuse IV over 1 hour at Weeks 0, 2, 4, then every 4 weeks x 1 year ☐ **MAINTENANCE:** Infuse IV over 1 hour every 4 weeks x 1 year
Cimzia® (certolizumab pegol)	☐ **INITIAL:** 400mg ☐ **MAINTENANCE:** ☐ 400mg ☐ 200mg	☐ **INITIAL:** Inject 400mg SUBQ at Weeks 0, 2, 4, then every 4 weeks x 1 year ☐ **MAINTENANCE:** Inject 400mg SUBQ every 4 weeks x 1 year ☐ **MAINTENANCE:** Inject 200mg SUBQ every 2 weeks x 1 year
Ilumya® (tildrakizumab)	100mg	☐ **INITIAL:** Inject SubQ at Weeks 0 and 4, then every 12 weeks x 1 year ☐ **MAINTENANCE:** Inject SubQ at every 12 weeks x 1 year
Infliximab and biosimilars Brands available: ☐ Avsola® ☐ Remicade® ☐ Inflectra® ☐ Renflexis®	☐ _____ mg (3 mg/kg) ☐ _____ mg (5 mg/kg) ☐ _____ mg (____ mg/kg)	☐ **INITIAL:** Infuse IV over 2 hours at Weeks 0, 2, 6, then every _____ weeks x 1 year ☐ **MAINTENANCE:** Infuse IV over 2 hours every _____ weeks x 1 year
IVIG ☐ Bivigam 10% ☐ Octagam 5% ☐ Panzyga 10% ☐ Octagam 10% ☐ Other Brand and Conc: _____	☐ **1 gm/kg:** _____ gm ☐ **2 gm/kg:** _____ gm ☐ **Other:** _____ gm (total)	☐ **INITIAL:** Infuse IV daily over ____ days. ☐ **MAINTENANCE:** Infuse IV daily over ____ days every ____ weeks x 1 year. ☐ **OTHER:** _____ Ramp up infusion over 90 minutes to maximum rate of 150 mL/hr (10% IVIG) or 250 mL/hr (5% IVIG), or as tolerated, then ramp down over 1 minute.
Orencia® (abatacept)	☐ **<60kg:** 500mg ☐ **60-100kg:** 750mg ☐ **>100kg:** 1000mg	☐ **INITIAL:** Infuse IV over 30 minutes at Weeks 0, 2, 4, then every 4 weeks x 1 year ☐ **MAINTENANCE:** Infuse IV over 30 minutes every 4 weeks x 1 year
Saphnelo® (anifrolumab)	300mg	☐ Infuse IV over 30 minutes every 4 weeks x 1 year
Simponi Aria® (golimumab)	☐ _____ mg (2mg/kg)	☐ **INITIAL:** Infuse IV over 30 minutes at Weeks 0, 4, then every 8 weeks x 1 year ☐ **MAINTENANCE:** Infuse IV over 30 minutes every 8 weeks x 1 year
Rituximab and biosimilars Brands available: ☐ Riabni® ☐ Ruxience® ☐ Rituxan® ☐ Truxima®	☐ 1000mg ☐ _____ mg	☐ Infuse IV over _____ hours on Days 1 and 15 every _____ weeks x 1 year ☐ 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

☐ Acetaminophen 650mg PO

☐ Diphenhydramine 25mg 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: _____

CPS Infusion · P: (770) 618-9616 · F: (770) 618-9617 · E: info@cpsinfusion.com

Patient Name: _____ DOB: _____

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, 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 Actemra, Cimzia, infliximab biosimilars, Orencia, Simponi Aria, and Rituxan (submit results to start therapy)

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

For Dermatopolymyositis or Polymyositis:

☐ Muscle biopsy report

For SLE:

☐ Positive autoantibody test (ANA, anti-dsDNA)

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

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____

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