HealthQuest
Infusion & Specialty

1311 W Sam Houston Pkwy N Ste 100, Houston, TX 77043
T 832.612.3500 F 866.612.3437

RHEUMATOLOGY REFERRAL FORM

E-SCRIPTS: NCPDP# 5902944 NPI# 1720383003

ACHC ACCREDITED

DATE _____ DATE NEEDED _____

SHIP TO: ☐ Patient ☐ Physician's Office ☐ HealthQuest Infusion

Please fax completed form along with copy of patient's insurance cards and any labs to 866.612.3437

Patient Name _____
Patient Address _____
City _____ State _____ Zip _____
Day Phone _____ Work Phone # _____
Cell Phone _____ E-mail _____
Date of Birth _____ SS # _____
☐ Female
☐ Male

Prescriber's Name _____
License # _____ DEA # _____
NPI # _____ UPIN # _____
Practice Name _____
Office Contact _____
Address _____ Suite # _____
City _____ State _____ Zip _____
Phone _____ Fax _____

DIAGNOSIS

Patient: Wt._____ Ht._____ Allergies: ☐ Latex ☐ Other, specify _____

ICD-10 DIAGNOSIS CODE ☐ L40.59 Psoriatic Arthritis ☐ M06.9 Rheumatoid Arthritis ☐ M19.9 Osteoarthritis (unspecified site)
☐ M32.10 LSE ☐ M45.9 Ankylosing Spondylitis ☐ M81.0 Osteoporosis (age-related, w/o current fracture) ☐ Other: _____

Previously treated for this condition? ☐ Yes ☐ No Medication(s) failed: _____

Patient currently taking methotrexate? ☐ Yes ☐ No **PPD (TB Test):** ☐ Yes ☐ No

Rheumatoid Factor Positive _____ Total Swollen Joints: _____

For Forteo T-score: _____ Date: _____ **Fracture history** Site: _____ Date: _____

Current medication, including OTC: _____

PRESCRIPTION

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
Actemra®	☐ 125mg/0.9mL PFS	☐ Inject 1 syringe SQ once/wk. ☐ Inject 1 syringe SQ every other wk.	☐ 4 wk. supply	
Benlysta®	☐ 120mg Vial ☐ 400mg Vial	☐ Infuse 10mg/kg = _____ mg IV wks. 0, 2 and 4 ☐ Infuse 10mg/kg = _____ mg IV every 4 wks.	# of vials: ____	
Cimzia®	☐ 200mg/1mL PFS ☐ 50mg/200mg Vial	☐ Initial Dose: inject 400mg SQ on Day 1 at wk. 2 and at wk. 4 ☐ Maintenance: inject 200mg SQ, every other wk. ☐ Maintenance: inject 400mg SQ, every other wk. ☐ Other: _____	☐ 4 wk. supply	
Cosentyx®	☐ Carton of one 150mg/mL single-use Sensoready® Pen (injection) ☐ Carton of two 150mg/mL (300mg dose) single-use Sensoready® Pen (injection) ☐ Carton of one 150mg/mL single-use prefilled syringe (injection) ☐ Carton of two 150mg/mL (300mg dose) single-use prefilled syringe (injection)	**Psoriatic Arthritis w/Coexistent Moderate to Severe Plaque Psoriasis** ☐ Loading Dose: inject 300mg (2 injections) SC at wks. 0, 1, 2, 3, and 4 ☐ Maintenance Dose: inject 300mg (2 injections) SC every 4 wks. **Other Psoriatic Arthritis or Ankylosing Spondylitis** ☐ With loading dose: inject 150mg (1 injection) SC at wks. 1, 2, 3 and 4, and then every 4 wks. thereafter. ☐ Without loading dose: inject 150mg (1 injection) SC every 4 wks. ☐ Other: _____		
Enbrel®	☐ 50mg Pen ☐ 50mg PFS ☐ 25mg Vial	☐ Inject SQ once/wk. ☐ Inject SQ twice/wk.	☐ 4 wk. supply	

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PRESCRIPTION (CONTINUED)

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
Forteo®	☐ 750mcg/3mL Pen	☐ Inject 20mcg daily as directed	☐ 4 wk supply	
Humira®	☐ 40mg/0.8mL Pen ☐ 40mg/0.8mL PFS	☐ Inject 40mg SQ every other wk. ☐ Inject 40mg SQ once/wk.	☐ 4 wk. supply	
ILARIS®	☐ 180mg lyophilized powder for solution	patients ≥ 7.5kg: inject 4mg/kg (w/max of 300mg) SC every 4 wks. ILARIS is supplied as a 180mg white lyophilized powder for solution for injection. Reconstitution with 1mL of preservative-free sterile water for injection is required prior to administration of the drug, resulting in a total volume of 1.2mL reconstituted solution.		
Kineret®	☐ 100mg PFS	☐ Inject 100mg SQ Daily	☐ 4 wk. supply	
Orencia®	☐ 125mg PFS ☐ 250mg Vial	☐ Inject 125mg SQ Wkly ☐ Infuse _____ mg _____ ☐ Other: _____	☐ 4 wk. supply	
Otezla®	☐ Titration starter pack	☐ Day 1: 10mg PO in the morning ☐ Day 2: 10mg PO in the morning and 10mg PO in the eve ☐ Day 3: 10mg PO in the morning and 20mg PO in the eve ☐ Day 4: 20mg PO in the morning and 20mg PO in the eve ☐ Day 5: 20mg PO in the morning and 30mg PO in the eve ☐ Day 6 and thereafter: 30mg PO twice daily.		
	☐ 30mg Vial	☐ Maintenance dose: 30mg PO twice Daily ☐ Other: _____		
Prolia®	☐ 60mg PFS ☐ 60mg Vial	☐ Inject 60mg SQ every 6 mos.	☐ 1	
Reclast®	☐ 5mg/100mL Vial	☐ 5mg IV once yearly	☐ 1	
Remicade®	☐ 100mg Vial ☐ 5mg/kg ☐ _____ mg/kg	☐ IV on weeks 0, 2, and 6 ☐ IV every 8 wks. ☐ IV every _____ wks.	# of vials: _____	
Rituxan®	☐ 100mg/10mL Vial ☐ 500mg/50ml Vial	☐ Sig _____	# of vials: _____	
Simponi®	☐ 50mg/0.5mL Pen ☐ 50mg/0.5mL PFS	☐ Inject 50mg SQ once monthly	☐ 1 mo. supply	
Simponi® ARIA™	☐ 50mg/4mL Vial	☐ Infuse 2mg/kg IV ☐ IV on weeks 0 and 4 ☐ IV every 8 wks.	# of vials: _____	
Stelara®	☐ 45mg/0.5mL PFS ☐ 90mg/mL PFS	☐ Initiation: inject SC on Day 1 ☐ Maintenance: inject SC on Day 29 and every 12 wks. thereafter	☐ 4 wk. supply	
Xeljanz®	☐ 5mg	☐ Take one 5mg tablet PO twice daily ☐ Other: _____		
Other:				

PRESCRIBER'S SIGNATURE (Signature required. No stamps.) _____ **DATE** _____