# HealthQuest Infusion & Specialty

# RHEUMATOLOGY REFERRAL FORM

1311 W Sam Houston Pkwy N Ste 100, Houston, TX 77043
**T** (832) 500-3727 **F** (832) 500-8629 **E** specialty@hqrx.com

DATE:_____ NEXT TREATMENT DATE:_____

**Please fax completed form along with copy of patient's insurance cards and any labs to (832) 500-8629**

Patient Name _____ Phone _____ Date of Birth _____ Provider Name _____

Practice Name _____ NPI# _____ Phone _____ Fax _____ Contact Person _____

## DIAGNOSIS

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

**ICD-10:** _____ **DIAGNOSIS:**

- ☐ Rheumatoid Arthritis, Unspecified
- ☐ Unspecified Iridocyclitis
- ☐ Arthropathic Psoriasis, Unspecified
- ☐ Rheumatoid Arthritis with Rheumatoid Factor, Unspecified
- ☐ Rheumatoid Arthritis without Rheumatoid Factor, Unspecified
- ☐ Wegener's granulomatosis
- ☐ Ankylosing Spondylitis, Unspecified
- ☐ Gout
- ☐ Systemic Lupus Erythematosus
- ☐ Other: _____

## PRESCRIPTION

| MEDICATION | INFUSION ORDERS | REFILLS |
|---|---|---|
| ☐ Actemra | ☐ 4 mg/kg IV every 4 weeks for_____ doses, then followed by 8mg/kg every 4weeks thereafter<br>☐ 4 mg/kg IV every 4 weeks ****Dose not to exceed 800mg in RA/CRS****<br>☐ 8 mg/kg IV every 4 weeks ****Dose not to exceed 600mg in GCA****<br>☐ Other dose:_____ mg IV every 4 weeks | |
| ☐ Cimzia | ☐ Initial Dose: 400mg subcutaneously at weeks 0, 2, and 4 weeks<br>Maintenance Dose: ☐ 200mg subcutaneously Q 2 weeks **OR** ☐ 400mg subcutaneously Q 4 weeks | |
| ☐ Krystexxa | ☐ 8mg IV every 2 weeks | |
| ☐ Immunoglobulin | ☐ IV ☐ SubQ<br>_____ gm/kg x _____day(s) **OR** divided over _____day(s) Brand:_____<br>_____ mg/kg x _____day(s) **OR** divided over _____day(s) *(HealthQuest to choose if not indicated)*<br>Frequency: Every _____ weeks or _____ | |
| ☐ Orencia | Orencia Dose:_____ mg IV<br>Frequency: ☐ Every 4 weeks OR ☐ 0, 2, 4 weeks, and every 4 weeks thereafter | |
| ☐ Simponi Aria | ☐ Initial Dose: 2mg/kg at weeks 0, 4, and then every 8 weeks<br>☐ Maintenance Dose: 2mg/kg every 8 weeks | |
| ☐ Stelara | Initial Dose: ☐ 45mg subcutaneously initially, 4 weeks later, followed by 45mg every 12 weeks<br>☐ 90mg subcutaneously initially, 4 weeks later, followed by 90mg every 12 weeks<br>Maintenance Dose: ☐ 45mg subcutaneously every 12 weeks<br>Maintenance Dose: ☐ 90mg subcutaneously every 12 weeks | |
| ☐ Infliximab | Dose:_____mg/kg ☐ May substitute biosimilar per insurance requirement<br>Frequency: ☐ Every_____weeks For HealthQuest use. Brand:_____<br>☐ 0, 2, 6, then every 8 weeks ☐ Do not substitute. Brand:_____ | |
| ☐ Rituximab | Dose: ☐ 1000mg ☐ Other:_____ ☐ May substitute biosimilar per insurance requirement<br>☐ 375mg/m2 For HealthQuest use. Brand:_____<br>Frequency: ☐ One time dose ☐ Weekly x4 weeks<br>☐ Day 0, repeat dose in 2 weeks ☐ Do not substitute. Brand:_____ | |
| ☐ Saphnelo | ☐ 300mg IV every 4 weeks | |

*Pharmacist may substitute brand based on product availability. If needed, dose to be rounded to nearest whole vial.*

**Premedication orders:** Tylenol ☐ 1000mg ☐ 500mg PO, please choose one antihistamine:
☐ Diphenhydramine 25mg PO ☐ Loratadine 10mg PO ☐ Cetirizine 10mg PO ☐ Quzyttir 10mg IVP

**Additional premedications:** ☐ Solu-Medrol _____ mg IVP ☐ Solu-Cortef _____ mg IVP ☐ Other: _____

**Lab orders:** _____ **Frequency:** ☐ Every infusion ☐ Other: _____

☐ Yearly TB testing QFT (optional) Required labs to be drawn by: ☐ HealthQuest ☐ Referring physician

**Anaphylactic Reaction Orders:**

- Epinephrine (based on patient weight)
  - >30kg (>66lbs): EpiPen 0.3mg or compounded syringe IM or subQ; may repeat in 5–10 minutes x1
  - 15–30kg (33–66lbs): EpiPen Jr. 0.15mg or compounded syringe IM or subQ; may repeat in 5–10 minutes x1
- Diphenhydramine: Administer 25–50mg orally OR IV (adult)
- NS 0.9% 500mL IV bolus as needed (adult)
- Refer to physician order or institutional protocol for pediatric dosing

**Flush orders:** NS 1–20mL pre/post infusion PRN and Heparin 10U/mL or 100U/mL per protocol as indiciated PRN

**I authorize HealthQuest Infusion & Specialty and its representatives to initiate and execute any insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above as well as selecting the preferred site of care for the patient. I understand that I can revoke this designation at any time by providing written notice to HealthQuest Infusion & Specialty.**

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

HealthQuest
Infusion & Specialty

# COMPREHENSIVE SUPPORT FOR RHEUMATOLOGY THERAPIES

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## PATIENT INFORMATION

Patient Name _____ Date of Birth _____

## REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL

☐ Include **signed** and **completed** order (MD/prescriber to complete page 1)
☐ Include patient demographic information and insurance information
☐ Include patient's medication list
☐ Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy
  ☐ For biologic orders, has the patient had a documented contraindication/intolerance or failed trial of a conventional therapy (i.e., steroids)? ☐ Yes ☐ No
  If yes, which drug(s)?
  ☐ For biologic orders, does the patient have a contraindication/intolerance or failed trial to any other biologic?
  ☐ Yes ☐ No
  If yes, which drug(s)?
☐ Include labs and/or test results to support diagnosis
☐ *If applicable* - Last known biological therapy: _____ and last date received: _____
If patient is switching to biologic therapies, please perform a wash-out period of weeks prior to starting ordered biologic therapy.
☐ Other medical necessity: _____

## REQUIRED PRE-SCREENING

☐ **TB screening test completed within 12 months - attach results**
Required for: Actemra, Cimzia, infliximab, Stelara, Simponi Aria, Orencia
☐ **Positive** ☐ **Negative**

☐ **Hepatitis B screening (Hepatitis B surface antigen) -** ☐ **Positive** ☐ **Negative**
*Required for: Actemra, Cimzia, infliximab, rituximab, Simponi Aria*

**Hepatitis B core antibody total (not IgM) -** ☐ **Positive** ☐ **Negative**
*Required for: rituximab*

☐ **Serum immunoglobulins - attach results** *Recommended for: rituximab*
☐ **Baseline creatinine - attach results** *Required for: IVIG*

*If TB or Hepatitis B results are positive - please provide documentation of treatment or medical clearance, and a negative CXR (TB+)

HealthQuest Infusion & Specialty will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and refer him/her to any available co-pay assistance as needed. Thank you for the referral.

**Please fax all information to (832) 500-8629**