AMERICAN RIVER INFUSION SERVICES	RHEUMATOLOGY REFERRAL FORM	FAX: Phone: (916)239-7900 Email: intake@arinfusion.com

PATIENT INFORMATION

Patient Name: _____
Home Address: _____
City, State, Zip: _____
Home Phone: _____
Cell Phone: _____
SS: _____
Date of Birth: _____ Gender: ☐ Male ☐ Female
Contact Person & #: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
Home Address: _____
City, State, Zip: _____
Phone: _____
Fax: _____
DEA: _____ License #: _____
NPI #: _____

INSURANCE INFORMATION (Please attach the front and back of insurance and prescription card)

Primary Insurance: _____ ID#: _____ Group: _____
Secondary Insurance: _____ ID#: _____ Group: _____
Prescription Card: _____ ID#: _____ BIN: _____ PCN: _____ Group: _____

DIAGNOSIS/ ICD 10 CODE

☐ _____
☐ _____

PRIOR FAILED MEDICATIONS

_____ _____
_____ _____

PATIENT EVALUATION

Patient Weight: _____ Kg/ Lbs. Height: _____ Inches/CM Allergies: _____ _____
Does pt. have any active Infection? ☐No ☐Yes **Date of** ☐negative ☐positive **TB Test:** _____ Is the pt. currently on Methotrexate? ☐Yes ☐No

PRESCRIPTION INFORMATION

Medication	Dose and Strength	Directions	Quantity	Refills
☐ Actemra© (Tocilizumab)	☐ 162mg PF Syringe ☐ 20mg/ml Vial	☐ Pts < 100Kg: 162 mg SC every other week (Max=162 mg SC every week) ☐ Pts ≥ 100Kg: 162 mg SC once a week ☐ Intravenous: _____(4mg/kg) every 4 weeks, up to 8 mg/kg (Max=800mg)	____days ____weeks	
☐ Cimzia© (Certolizumab)	☐ Cimzia Starter kit ☐ 200mg Vial	☐ Induction Dose: 400mg SC on Day 1 and at weeks 2 and 4 ☐ Maintenance Dose: Inject 200 mg SC every other week ☐ Maintenance Dose: Inject 400 mg SC every 4 weeks	____days ____weeks	
☐ Enbrel© (Etanercept)	☐ 50mg Syringe ☐ 50mg Sure-click	☐ 50mg SC once a week. ☐ 50mg SC twice a week (Max duration 3 months)	____days ____weeks	
☐ Humira© (Adalimumab)	☐ 40 mg Syringe/Pen ☐ 20mg Syringe	☐ 40mg SC every other week (☐ Induction Dose: 80 mg x1, for PsA) ☐ Other: _____	____days ____weeks	
☐ Orencia© (Abatacept)	☐ 125 mg Syringe ☐ 250 mg Vials	☐ 125 mg SC once a week ☐ Induction Dose: Infuse _____mg Day 1, week 2, and week 4 ☐ Maintenance Dose: Infuse _____mg every 4 weeks	____days ____weeks	
☐ Remicade© (Infliximab)	☐ 100mg / 20 ml vial in 250 mL of 0.9% NS	☐ Induction Dose: IV at 5mg/kg (Dose =_____mg) at 0, 2 and 6 weeks ☐ Maintenance Dose: IV at 5mg/kg (Dose =_____mg) every 8 weeks ☐ Other: _____	____days ____weeks	
☐ Simponi-Aria© (Golimumab)	☐ 50 mg/ml vial ☐ 100 mg/ml vial	☐ Intravenous: 2mg/kg IV at week 0, week 4 then every 8 weeks ☐ SubQ: 50 mg once a month (in combination with methotrexate)	____days ____weeks	
☐ Other				

Other Medications

PREMEDICATE: ☐ **Diphenhydramine (Benadryl)**_____mg ☐ PO ☐ Inj. ☐ **APAP (Tylenol)**_____mg PO ☐ Other: _____
PRN for Anaphylactic Reaction: ☐ **Hydrocortisone 100mg** IV Push ☐ **Epinephrine 0.3mg IM** **Sodium Chloride 0.9%**: ☐ 250 ml ☐ 500 ml

☐ Sodium Chloride 0.9% **Flush** ☐3 ml ☐5 ml ☐10 ml ☐20 ml ☐30 ml ☐ Flush IV line before and after infusion ☐Labs _____
☐ Heparin Flush **10** units/ml ☐3 ml ☐5 ml ☐ Heparin Flush **100** units/ml ☐3 ml ☐5 ml ☐ Flush IV line after infusion

NURSING: Requires Placement ☐ PIV ☐ Midline IV Line for administration and nurse to administer infusion in home

Current IV Access: ☐PIV ☐PICC ☐Midline ☐PORT ☐OTHER_____ **Number of Lumens** Delivery Method: ☐ Gravity ☐ Infusion Pump
Therapy Start Date: _____ Length of Therapy: _____ Pharmacy to coordinate home health nursing visit as necessary: ☐ Yes ☐ No

By signing this form and utilizing our services, you are authorizing Home Infusion Group, Inc. and it's employees to serve as your authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber Signature: _____ (required) **Date:** _____ (required)