CureStat Rx
Home Infusion and Specialty Pharmacy

RHEUMATOLOGY REFERRAL FORM

Phone: (888)963-6544 Fax: (858)281-0045

PATIENT INFORMATION ☐ Deliver Here

Patient Name: _____
DOB: _____ Gender: ☐ Male ☐ Female
Address: _____
City_____ State_____ Zip: _____
Primary Phone: _____ SSN: _____
Caregiver Name: _____
Alternate Phone: _____

PRESCRIBER INFORMATION ☐ Deliver Here

Prescriber Name: _____
State License #: _____ DEA #: _____
NPI #: _____
Address: _____
City_____ State_____ Zip: _____
Phone: _____ Fax: _____
Contact Person: _____ Phone: _____

Insurance Information (please fax a copy of front and back of the insurance card(s))

Primary Insurance:_____ Plan ID: _____BIN #:_____ PCN #: _____ Grp #: _____
Secondary Insurance:_____ Plan ID: _____BIN #:_____ PCN #: _____ Grp #: _____

Clinical Information

Diagnosis: ☐ M06.9 Rheumatoid Arthritis ☐ M08.0 Juvenile Idiopathic Arthritis ☐ L40.59 Psoriatic Arthritis ☐ L40.54 Psoriatic Juvenile Arthritis
☐ M45.9 Ankylosing Spondylitis ☐ Other (ICD-10 code with description) _____
Diagnosis Date: _____ TB/PPD test: ☐ Positive ☐ Negative Wt: _____ ☐ Kg ☐ lbs Ht: _____ ☐ cm ☐ in

Prior Therapy ☐ Yes ☐ No	Reason for Discontinuation of therapy	Start date	End Date

Allergies: ☐ NKDA ☐ Other: _____
Comorbidities: _____
Concomitant Medications: _____

Drug	Dose/Strength	Directions	Qty	Refills
☐ **ACTEMRA** (tocilizumab)	☐ 162mg/0.9mL Prefilled syringe ☐ 162mg/0.9mL Autoinjector	☐ For patients weighing< 100kg: Inject 162mg SC every other week, Increase to every week based on clinical response. ☐ For patients weighing ≥ 100kg: Inject 162mg SC every week		
	☐ 80mg/4mL Vial ☐ 200mg/10mL Vial ☐ 400mg/20mL Val	☐ Starter dose: Infuse 4mg/kg every 4 weeks ☐ Maintenance dose: Infuse 8mg/kg every 4 weeks ☐ Other: _____		
☐ **CIMZIA** (certolizumab)	☐ 200 mg/mL Prefilled Syringe ☐ 200mg Vial	☐ Loading Dose: Inject 400mg SC at week 0, week 2 and week 4 ☐ Maintenance Dose: Inject 200mg SC every 2 weeks ☐ Maintenance Dose: Inject 400mg SC every 4 weeks		
☐ **COSENTYX** (Secukinumab)	☐ 150mg/mL Sensoready Pen ☐ 150mg/mL Prefilled Syringe ☐ 150mg Vial	<u>For Plaque Psoriasis and Psoriatic arthritis with coexistent Plaque Psoriasis:</u> ☐ Loading dose: Inject 300mg SC at weeks 0,1,2,3 and 4 ☐ Maintenance Dose: Inject 300mg SC every 4 weeks <u>For Psoriatic arthritis and Ankylosing Spondylitis:</u> ☐ Loading Dose: Inject 150mg SC at weeks 0, 1, 2, 3, and 4 ☐ Maintenance Dose: Inject 150mg SC every 4 weeks ☐ Other: _____		
☐ **ENBREL** (Etanercept)	☐ 25mg/0.5mL Prefilled Syringe ☐ 50mg/mL Prefilled Syringe ☐ 50mg/mL Prefilled SureClick autoinjector ☐ 25mg Vial ☐ 50mg/mL Mini prefilled Cartridge	☐ Inject 50mg SC once weekly ☐ Inject 50mg SC twice weekly ☐ Inject _____mg (0.8mg/kg) SC every week		

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Drug	Dose/Strength	Directions	Qty	Refills
☐ **HUMIRA** (Adalimumab)	☐ 10mg/0.2mL Prefilled syringe ☐ 20mg/0.2mL Prefilled Syringe ☐ 40mg/0.8mL Pen ☐ 40mg/0.4mL Pen ☐ 40mg/0.8mL Prefilled Syringe ☐ 40mg/0.4mL Prefilled Syringe	☐ Inject 10mg SC every OTHER week (10 to <15kg) ☐ Inject 20mg SC every OTHER week (15 to <30kg) ☐ Inject 40mg SC every OTHER week (≥30kg) ☐ Inject 40mg SC every week ☐ Other: _____		
☐ **ILARIS** (canakinumab)	☐ 150mg/mL Injection solution	For patients weighing ≥ 7.5 kg: ☐Inject _____mg (4 mg/kg, maximum of 300 mg) SC every 4 weeks		
☐ **INFLECTRA** (Infliximab) ☐ **REMICADE** (Infliximab) ☐ **RENFLEXIS** (Infliximab)	☐ 100mg Vial	☐ Inject _____mg (5mg/kg) IV at Weeks 0,2 and 6 ☐ Inject _____mg (5mg/kg) IV every 6 weeks ☐ Inject _____mg (5mg/kg) IV every 8 weeks In combination with methotrexate: ☐ Inject _____mg (3mg/kg) IV at Weeks 0,2 and 6 ☐ Inject _____mg (3mg/kg) IV every 8 weeks ☐ Other: _____		
☐ **KEVZARA** (Sarilumab)	☐ 150 mg/1.14 mL Prefilled Syringe ☐ 150 mg/1.14 mL Pen ☐ 200 mg/1.14 mL Prefilled Syringe ☐ 200 mg/1.14 mL Pen	☐ Inject 200mg SC every 2 weeks ☐ Other: _____		
☐ **ORENCIA** (Abatacept)	☐ 50 mg/0.4 mL Prefilled Syringe ☐ 87.5 mg/0.7 mL Prefilled Syringe ☐ 125 mg/mL Prefilled Syringe ☐ 125 mg/mL Autoinjector	☐ Inject 50mg SC once weekly ☐ Inject 87.5mg SC once weekly ☐ Inject 125mg SC once weekly ☐ Other: _____		
	☐ 250mg Vial	☐ Infuse _____mg IV at Week 0,2 and 4 ☐ Infuse _____mg IV every 4 weeks ☐ Other: _____		
☐ **OLUMIANT** (Baricitinib)	☐ 2mg Tablet	☐ Take 2mg by mouth once daily ☐ Other: _____		
☐ **OTELZA** (Apremilast)	☐ Starter pack	☐ Take as directed per package instructions		
	☐ 30mg Tablet	☐ Take 30mg by mouth twice daily Other: _____		
☐ **RITUXAN** (Rituximab)	☐ 100 mg/10 mL Vial ☐ 500 mg/50 mL Vial	☐ Infuse _____mg IV every _____ week(s).		
☐ **SIMPONI** (Golimumab)	☐ 50 mg/0.5 mL Prefilled syringe ☐ 50 mg/0.5 mL Autoinjector	☐ Inject 50mg SC once a month		
☐ **SIMPONI ARIA** (Golimumab)	☐ 50 mg/4 mL Vial	☐ Infuse _____mg (2 mg/kg) IV over 30 minutes at weeks 0 and 4, then every 8 weeks.		
☐ **STELARA** (Ustekinumab)	☐ 45 mg/0.5 mL Prefilled Syringe ☐ 90 mg/mL Prefilled Syringe ☐ 45 mg/0.5 mL Vial	For patients weighing ≤ 100 kg (220 lbs): Inject 45 mg SC initially and 4 weeks later, followed by 45 mg every 12 weeks. For patients weighing > 100 kg (220 lbs): Inject 90 mg SC initially and 4 weeks later, followed by 90 mg every 12 weeks. Other: _____		
☐ **TALTZ** (Ixekizumab)	☐ 80 mg/mL Autoinjector ☐ 80 mg/mL Prefilled Syringe	☐ Loading Dose: Inject 160mg SC at week 0 ☐ Maintenance Dose: Inject 80mg SC every 2 weeks ☐ Maintenance Dose: Inject 80mg SC every 4 weeks		
☐ **XELJIANZ/XELJIANZ XR** (Tocfacitinib)	☐ 5mg Tablet ☐ 11mg XR Tablet	☐ Give 5mg by mouth twice daily ☐ Give 11mg by mouth once daily ☐ Other: _____		

Injection training Provided by: ☐ Prescriber's office ☐ Pharmacy ☐ Other: _____

☐ Product substitution permitted ☐ Dispense as written

Prescriber's Signature: _____ Date: _____