Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy. Prescribers are reminded patients may choose any pharmacy of their choice.

INFINITY CARE SOLUTIONS
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Rheumatology Referral Form

Ship to: ❑Patient ❑Prescriber ❑ Pick Up (location):_____ Date Needed:_____ ❑Need Nurse ❑Need Training

PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name:	Prescriber Name:
Address:	NPI#: DEA#
City: State: Zip:	Address:
Phone: ( ) Alt Phone: ( )	City: State: Zip:
Emergency Contact Name:	Phone: ( ) Fax: ( )
Emergency Contact Phone: ( )	Nurse/Key Office Contact:
Patient Soc. Sec#: Date of Birth: / /	
Sex: ❑ Male ❑Female Weight lbs/kg Height	
Allergies:	

CLINICAL INFORMATION *(Please FAX recent clinical notes, labs, tests & current medication list with prescription)*

Diagnosis
❑M05.4_____ Rheumatoid Arthritis*
**Please include specific sites affected in clinic notes or write in space below*
Sites affected_____
❑ L40.5 Psoriatic Arthritis
❑Other_____
Date of diagnosis (or years with disease):_____
TB/PPD test given? ❑Yes ❑No Date:_____ Results?_____

Prior and Current Treatment *(please attach list if necessary)*
Is the patient currently being treated or previously been treated for Rheumatoid Arthritis or diagnosis indicated? ❑Yes ❑No
If yes, name the product(s), approximate date range(s) and response/outcome, listing current therapy first if applicable.
Product:_____ Date Range:_____ to _____ Response/outcome:_____
Product:_____ Date Range:_____ to _____ Response/outcome:_____
Product:_____ Date Range:_____ to _____ Response/outcome:_____
Does patient have any contraindications or intolerances to any Rheumatoid Arthritis medications? ❑Yes ❑No
If yes, please name medication and describe contraindication or reaction?_____

PRESCRIPTION INFORMATION

DRUG	DOSE	DIRECTIONS	QUANTITY	REFILLS
Actemra®	❑ 162mg/0.9mL PFS	❑ ≤100kg Body Weight: 162mg SC every OTHER week OR ❑ >100kg Body Weight: 162mg SC once weekly	1 carton=2 PFS	
Cimzia®	❑ Starter Kit 200mg PFS ❑ 200mg/mL PFS	❑ Initial: 400mg SC at weeks 0, 2, & 4, then maintenance Maintenance: ❑ 200mg SC every other week OR ❑ 400mg SC every 4 weeks	1 Kit= 6 x 200mg/mL PFS 1 Carton= 2 x 200mg/mL PFS	
Enbrel®	❑ 50mg/mL SureClick® Autoinjector ❑ 50mg/mL PFS	❑ Inject 50mg SC once weekly	1 Carton=4 x 50mg/mL	
Humira®	❑ 40mg/0.8mL Pen ❑ 40mg/0.8mL PFS	❑ 40mg SC every OTHER week OR ❑ 40mg SC once weekly for patients NOT receiving methotrexate	1 carton=2 x 40mg/0.8mL	
Orencia®	❑ 125mg/mL PFS	❑ 125mg SC once weekly	1 carton=4 x 125mg/mL PFS	
Otezla®	❑ Starter pack 28 day ❑ 30mg tablet	❑ Day 1: 10mg in AM; Day 2: 10mg in AM and 10 mg in PM; Day 3: 10mg in AM and 20mg in PM; Day 4: 20mg in AM and 20mg in PM; Day 5: 20mg in AM and 30mg in PM; Day 6 and thereafter: 30mg twice daily ❑ Maintenance: 30mg PO twice daily	1 Starter Pack=4 week supply 60 tablets	
Simponi®	❑ 50mg/0.5mL SmartJect® Autoinjector ❑ 50mg/0.5mL PFS	❑ Inject 50mg SC once monthly	1 Carton=1 x 50mg/0.5mL dose	
Stelara®	❑ 45mg/0.5mL PFS ❑ 90mg/1mL PFS	❑ ≤100kg Body Weight: Inject 45mg SC at weeks 0 and 4, then every 12 weeks thereafter ❑ >100kg Body Weight: Inject 90mg SC at weeks 0 and 4, then every 12 weeks thereafter	1 Carton=1 x 45mg/0.5mL dose 1 Carton=1 x 90mg/1mL dose	
Xeljanz®	❑ 5mg tablet	❑ Take 5mg PO twice daily	60 tablets	
Other	❑ _____	❑ _____		
Other	❑ _____	❑ _____		

INSURANCE INFORMATION: PLEASE FAX COPY OF INSURANCE CARDS (FRONT & BACK)

To Prescriber: *By signing this form and utilizing our services, you are authorizing Infinity Care Solutions, a division of Infinity Compounding Solutions, LLC, its agents and employees, to serve as your prior authorization designated agent in dealing with medical or prescription claims payors, processors and other entities.*

Prescriber's Signature: _____Date_____