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:
Patient Soc. Sec#: Date of Birth: / /	Phone: ( ) Fax: ( )
Sex: ❑ Male ❑Female Weight lbs/kg Height	Nurse/Key Office Contact:
Allergies:	Tax ID#:

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

Diagnosis
❑M06.9 Rheumatoid Arthritis
❑ L40.59 Psoriatic Arthritis
❑ L40.54 Psoriatic Juvenile 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 medications? ❑Yes ❑No
If yes, please name medication and describe contraindication or reaction?_____

PRESCRIPTION INFORMATION

DRUG	DOSE	DIRECTIONS	QUANTITY	REFILL
Actemra®	❑ 162mg/0.9mL PFS	❑ **<100kg Body Weight:** Inject 162mg SC every OTHER week ❑ **≥100kg Body Weight:** Inject 162mg SC once weekly	❑ 4 x 162mg/0.9mL ❑ 2 x 162mg/0.9mL	_____
Cimzia®	❑ Starter Kit 200mg PFS ❑ 200mg/mL PFS	❑ Initial: Inject 400mg SC at weeks 0, 2, & 4 Maintenance: ❑ Inject 200mg SC every other week ❑ Inject 400mg SC every 4 weeks	❑ 6 x 200mg/mL ❑ 2 x 200mg/mL	0 _____
Cosentyx®	❑ 150mg/mL Sensoready® Pen ❑ 150mg/mL PFS	Initial: ❑ Inject 300mg SC at weeks 0, 1, 2, and 3 ❑ Inject 150mg SC at weeks 0, 1, 2, and 3 Maintenance: ❑ Inject 300mg SC at week 4, then every 4 weeks thereafter ❑ Inject 150mg SC at week 4, then every 4 weeks thereafter	 ❑ 8 x 150mg/mL ❑ 4 x 150mg/mL ❑ 2 x 150mg/mL ❑ 1 x 150mg/mL	 0 0 _____ _____
Enbrel ®	❑ 50mg/mL SureClick® Autoinjector ❑ 50mg/mL PFS ❑ 25mg/mL vials ❑ 25mg/mL PFS	❑ Inject 50mg SC once weekly ❑ Inject _____mg (0.8mg/kg x _____kg) SC once weekly	❑ 4 x 50mg/mL ❑ 4 x 25mg/mL Other_____	_____ _____
Humira®	❑ 40mg/0.4mL Pen **CF** ❑ 40mg/0.4mL PFS **CF** ❑ 40mg/0.8mL Pen ❑ 40mg/0.8mL PFS	❑ Inject 40mg SC every OTHER week ❑ Inject 40mg SC once weekly	❑ 2 injections ❑ 4 injections ❑ Other: _____	_____ _____
Kevzara®	❑ 150mg/1.14mL PFS ❑ 200mg/1.14mL PFS	❑ Inject 150mg SC every other week ❑ Inject 200mg SC every other week	❑ 2 x 150mg/1.14mL ❑ 2 x 200mg/1.14mL	_____ _____
Olumiant®	❑ 2mg tablet	❑ Take 1 tablet by mouth daily	❑ 30 tablets	_____
Orencia®	❑ 125mg/mL PFS ❑ 125mg/mL Clickject™	❑ Inject 125mg SC once weekly	❑ 4 x 125mg/mL	_____
Otezla®	❑ Starter pack 28 day	❑ Take as directed by mouth per package instructions	❑ 55 tablets	0
	❑ 30mg tablet	❑ 30mg PO twice daily ❑ 30mg PO once daily (For patients with severe renal impairment)	❑ 60 tablets ❑ 30 tablets	_____ _____
Simponi®	❑ 50mg/0.5mL SmartJect® Autoinjector ❑ 50mg/0.5mL PFS	❑ Inject 50mg SC once monthly	❑ 1 x 50mg/0.5mL	_____
Stelara®	❑ **≤100kg Body Weight**: 45mg/0.5mL PFS	❑ Loading/induction: Inject 45mg SC at week 0 ❑ Maintenance: Inject 45mg SC on day 29 and every 12 weeks thereafter	❑ 1 x 45mg/0.5mL ❑ 1 x 45mg/0.5mL	0 _____
	❑ **>100kg Body Weight**: 90mg/1mL PFS	❑ Loading/induction: Inject 90mg SC at week 0 ❑ Maintenance: Inject 90mg SC on day 29 and every 12 weeks thereafter	❑ 1 x 90mg/mL ❑ 1 x 90mg/mL	0 _____
Taltz®	❑ 80mg/mL Autoinjector ❑ 80mg/mL PFS	❑ Loading: Inject 160mg (2 x 80mg) SC at week 0 ❑ Maintenance: Inject 80mg SC at week 4 and every 4 weeks thereafter	❑ 2 x 80mg/mL ❑ 1 x 80mg/mL	0 _____
Xeljanz®	❑ 5mg tablet	❑ Take 5mg PO twice daily	❑ 60 tablets	_____
Xeljanz® XR	❑ 11mg tablet	❑ Take 11mg PO once daily	❑ 30 tablets	_____

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 payers, processors and other entities.*

Date: _____ _____ _____

DISPENSE AS WRITTEN **MAY SUBSTITUTE**