

Patient Status: ☐ NEW\* ☐ CONTINUING

Next Due Date (if applicable) \_\_\_\_\_ Choose Location \_\_\_\_\_

\*Include recent labs and last 2 office visit notes

Name \_\_\_\_\_ DOB \_\_\_\_\_

Phone \_\_\_\_\_ Other Phone \_\_\_\_\_

Email \_\_\_\_\_ SSN \_\_\_\_\_

Allergies \_\_\_\_\_ Weight \_\_\_\_\_ ☐ LBS ☐ Kg Gender ☐ M ☐ F

## INSURANCE INFORMATION (Required)

Submit copies of the front and back of primary and/or secondary insurance cards with this referral

Physician Name \_\_\_\_\_ NPI# \_\_\_\_\_

License # \_\_\_\_\_ TIN# \_\_\_\_\_ DEA# \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Office Contact \_\_\_\_\_ Email \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

### DIAGNOSIS INFORMATION:

- ☐ Rheumatoid Arthritis \_\_\_\_\_ ☐ Systemic Juvenile Idiopathic Arthritis \_\_\_\_\_  
☐ Polyarticular Juvenile Idiopathic Arthritis \_\_\_\_\_ ☐ Other \_\_\_\_\_

\*Required Labs: Hep B required; TB within last year required (prior to starting only)

### DOSING

MAX DOSE: 800mg

Weight-based; however, if calculation is >800mg, the MAX allowable dose is 800mg

☐ Administer \_\_\_\_\_ mg/kg IV every \_\_\_\_\_ week(s)

☐ Vital signs per HI Protocol

☐ Anaphylaxis & Hydration Management per HI Protocol

### PRE-MEDICATIONS ☐ N/A

- ☐ Acetaminophen ☐ 500mg ☐ 650mg ☐ 1000mg  
☐ Fexofenadine (Allegra) 180mg PO (or other non-sedating antihistamine)  
☐ Diphenhydramine (Benadryl) ☐ 25mg ☐ 50mg ☐ PO ☐ IV (requires driver)  
☐ Methylprednisolone (Solu-Medrol) ☐ 40mg ☐ 80mg ☐ 125mg IV  
☐ Prednisone \_\_\_\_\_ mg PO  
☐ Other \_\_\_\_\_

### POST-MEDICATIONS ☐ N/A

- ☐ Acetaminophen ☐ 500mg ☐ 650mg ☐ 1000mg  
☐ Prednisone \_\_\_\_\_ mg PO  
☐ Other \_\_\_\_\_

### LABS

- ☐ CBC w/Diff ☐ Each Infusion ☐ Other Frequency (specify): \_\_\_\_\_  
☐ CRP ☐ Each Infusion ☐ Other Frequency (specify): \_\_\_\_\_  
☐ CMP ☐ Each Infusion ☐ Other Frequency (specify): \_\_\_\_\_  
☐ ESR ☐ Each Infusion ☐ Other Frequency (specify): \_\_\_\_\_  
☐ Hepatic Panel ☐ Each Infusion ☐ Other Frequency (specify): \_\_\_\_\_  
☐ Renal Panel ☐ Each Infusion ☐ Other Frequency (specify): \_\_\_\_\_  
☐ Quantiferon TB Gold, annually, last completed (date): \_\_\_\_\_  
☐ Other (specify): \_\_\_\_\_

Provider Signature \_\_\_\_\_

Date \_\_\_\_\_

For new referrals, please include recent labs and last two office visit notes.

Fax Referrals to: Kentucky (888) 977-0914 | New York (315) 457-4305 | Ohio (888) 977-0914 | Pennsylvania (724) 240-1586