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PATIENT INFORMATION

Patient Name: _____ DOB: _____ Phone: _____

Patient Status: New to Therapy Continuing Therapy Next Treatment Date: _____

MEDICAL INFORMATION

Patient Weight: _____ lbs. Patient Height: _____ Allergies: _____

ICD-10: _____ Diagnosis: _____

<input type="checkbox"/> Rheumatoid Arthritis, Unspecified	<input type="checkbox"/> Wegener's granulomatosis
<input type="checkbox"/> Unspecified Iridocyclitis	<input type="checkbox"/> Ankylosing Spondylitis, Unspecified
<input type="checkbox"/> Arthropathic Psoriasis, Unspecified	<input type="checkbox"/> Gout
<input type="checkbox"/> Rheumatoid Arthritis with Rheumatoid Factor, Unspecified	<input type="checkbox"/> Systemic Lupus Erythematosus
<input type="checkbox"/> Rheumatoid Arthritis without Rheumatoid Factor, Unspecified	<input type="checkbox"/> Other: _____

THERAPY ORDER

Drug	Dosing	Refill
Actemra	<input type="checkbox"/> 4 mg/kg IV every 4 weeks for _____ doses, then followed by 8mg/kg every 4 weeks thereafter <input type="checkbox"/> 4 mg/kg IV every 4 weeks <input type="checkbox"/> 8 mg/kg IV every 4 weeks <input type="checkbox"/> Other dose: _____ mg IV every 4 weeks	
Cimzia	<input type="checkbox"/> Initial Dose: 400mg subcutaneously at weeks 0, 2, and 4 weeks Maintenance Dose: <input type="checkbox"/> 200mg subcutaneously Q 2 weeks OR <input type="checkbox"/> 400mg subcutaneously Q 4 weeks	
Krystexxa	<input type="checkbox"/> 8mg IV every 2 weeks	
Immunoglobulin	<input type="checkbox"/> IV <input type="checkbox"/> SubQ _____ gm/kg x _____ day(s) OR divided over _____ day(s) _____ mg/kg x _____ day(s) OR divided over _____ day(s) Frequency: Every _____ weeks or _____ Brand: _____ (Compassus to choose if not indicated)	
Orencia	Orencia Dose: _____ mg IV Frequency: <input type="checkbox"/> Every 4 weeks OR <input type="checkbox"/> 0, 2, 4 weeks, and every 4 weeks thereafter	
Simponi Aria	<input type="checkbox"/> Initial Dose: 2mg/kg at weeks 0, 4, and then every 8 weeks <input type="checkbox"/> Maintenance Dose: 2mg/kg every 8 weeks	
Stelara	Initial Dose: _____ <input type="checkbox"/> 45mg subcutaneously initially, 4 weeks later, followed by 45mg every 12 weeks <input type="checkbox"/> 90mg subcutaneously initially, 4 weeks later, followed by 90mg every 12 weeks Maintenance Dose: <input type="checkbox"/> 45mg subcutaneously every 12 weeks Maintenance Dose: <input type="checkbox"/> 90mg subcutaneously every 12 weeks	
Infliximab	Dose: _____ mg/kg Frequency: <input type="checkbox"/> Every _____ weeks <input type="checkbox"/> 0, 2, 6, then every 8 weeks <input type="checkbox"/> May substitute biosimilar per insurance requirement For Compassus use Brand: _____ <input type="checkbox"/> Do not substitute. Brand: _____	
Rituximab	Dose: <input type="checkbox"/> 1000mg <input type="checkbox"/> Other: _____ <input type="checkbox"/> 375mg/m ² Frequency: <input type="checkbox"/> One time dose <input type="checkbox"/> Weekly x4 weeks <input type="checkbox"/> Day 0, repeat dose in 2 weeks <input type="checkbox"/> Do not substitute. Brand: _____ <input type="checkbox"/> May substitute biosimilar per insurance requirement For Compassus use Brand: _____	
SaphneLo	<input type="checkbox"/> 300mg IV every 4 weeks	

Premedication orders: Tylenol 1000mg 500mg PO, please choose one antihistamine: Diphenhydramine 25 mg PO Loratadine 10mg PO Cetirizine 10mg Quzyttir 10mg IVP**Additional premedications:** Solu-Medrol _____ mg IVP Solu-Cortef _____ mg IVP Other _____**Lab orders:** _____ **Lab frequency:** _____ Yearly TB QFT (optional) Baseline HepBcAB total

PROVIDER INFORMATION

By signing this form and utilizing our services, you are authorizing Compassus and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient.

Provider Name: _____ Signature: _____ Date: _____

Provider NPI: _____ Phone: _____ Fax: _____ Contact Person: _____

PREFERRED LOCATION

City: _____ State: _____

Compassus

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee and contains material that is confidential, privileged property, or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately and destroy all copies if you have received this document in error.



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REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING AND INSURANCE APPROVAL

- Include signed and completed order (MD/prescriber to complete page 1)
- Include patient demographic information and insurance information
- Include patient's medication list
- Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy
- For biologic orders, has the patient had a documented contraindication/intolerance or failed trial of a conventional therapy (i.e., steroids)?
 - Yes No If yes, which drug(s)? _____
- For biologic orders, does the patient have a contraindication/intolerance or failed trial to any other biologic?
 - Yes No If yes, which drug(s)? _____
- Include labs and/or test results to support diagnosis
- If applicable - Last known biological therapy: _____ and last date received: _____.
If patient is switching to biologic therapies, please perform a washout period of _____ weeks prior to starting ordered biologic therapy.
- Other medical necessity: _____

REQUIRED PRE-SCREENING (BASED ON DRUG THERAPY)

- TB screening test completed within 12 months - attach results**
Required for: Actemra, Cimzia, infliximab, Stelara, Simponi Aria, Orencia
 Positive Negative
- Hepatitis B screening (Hepatitis B surface antigen) - Positive Negative**
Required for: Actemra, Cimzia, infliximab, rituximab, Simponi Aria
Hepatitis B core antibody total (not IgM) - Positive Negative
Required for: rituximab
- Serum immunoglobulins - attach results** Recommended for: rituximab
- Baseline creatinine - attach results** Required for: IVIG

*If TB or Hepatitis B results are positive - please provide documentation of treatment or medical clearance, and a negative CXR (TB+)

Compassus will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and refer him/her to any available co-pay assistance as needed. Thank you for the referral.

Please fax all information to

or call

for assistance