RHEUMATOLOGY

Referral Phone: 800-622-9321
Referral Fax: 614-367-1684

DECILLION HEALTHCARE

Demographics

Last Name: | First Name: | Circle one: M F | D.O.B.

Home Address: | City: | State: | Zip:

Height: | Weight: | Allergies:

Preferred Method of Contact: ☐ Email ☐ Phone (Home): Phone (Cell): Phone (Work):

Email: ____ Last 4 of SSN #: _________________________ Primary Language _______________________

Insurance

Primary Insurance: *Complete and Attach Copies of card | City: | State: | Phone:

Card Holder Name: | ID #: | Group #:

Employer: | Prescription Card: | City: | State: | Phone:

Medical Necessity

Statement of Medical Necessity Date:

Diagnosis: ☐ 714.0 Rheumatoid Arthritis ☐ 720.0 Ankylosing Spondylitis ☐ 714.31 Polyarticular Juvenile Idiopathic Arthritis ☐ 696.0 Psoriatic Arthritis
☐ Other:____

Other Clinical Info/Comments:

Is patient also taking methotrexate? ___Y ___N Does the patient have heart failure? ___Y ___N Does the patient have any active infection? ___Y ___N
Does the patient have chronic hepatitis B? ___Y ___N TB/PPD Test given? ___Y ___N Results: ___Positive ___Negative
Prior Failed Medications:
Medication: Duration of Treatment/Reason for D/C Orencia® / Remicade ® / Rituxan ®: WEIGHT____lbs or ___kgs
_______________________________ _______________________________________ Other concurrent medications:__________________________

Prescription

Medication	Strength	Directions	Qty	Refills
☐ Actemra ®	☐ 162mg/0.9mL Prefilled Syringe ☐ 80mg/4mL ☐ 200mg/10mL ☐ 400mg/20mL ____mg/kg	☐ Patients less than 100 kg weight 162 mg administered SubQ every other week, followed by an increase to every week based on clinical response ☐ Patients at above 100 kg weight 162 mg administered SubQ every week ☐ Initial Dose: 4mg/kg every 4 weeks ☐ Maint. Dose: (based on clinical response) 8mg/kg every 4 weeks ☐ Other:____		
☐ Cimzia ®	☐ Cimzia ® Starter Kit ☐ 200 mg/ml Prefilled Syringe ☐ 200 mg Lypholyzed Powder	☐ Initial Dose: Inject 400mg SC at weeks 0, 2, and 4, then: Maintenance Dose ☐ 200mg SC every other week ☐ 400mg SC every 4 weeks ☐ Other:	1 kit = 6 vials 4 week supply	0
☐ Enbrel ®	☐ 50 mg/ml Sureclick AutoInjector ☐ 50 mg/ml Prefilled Syringe ☐ 25mg/0.5ml Prefilled Syringe ☐ 25mg Vial	☐ Inject 50 mg SC ONCE a week ☐ Inject 25 mg SC TWICE a week (72-96 hours apart) ☐ Other______________________________	4 week supply Other_____	
☐ Humira ®	☐ 40mg/0.8ml Pen ☐ 40mg/0.8ml Prefilled Syringe ☐ 20mg/0.4ml Prefilled Syringe	☐ Inject 40 mg SC every OTHER week ☐ Inject 20 mg SC every OTHER week	4 week supply Other_____	
☐ ILARIS ®	☐ 4mg/kg (w/ max of 300mg) for patients w/ a body wt. greater than or equals to 7.5kg	☐ Administer SubQ every 4 wks. ILARIS is supplied as a 180mg white lyphilized powder for solution for SubQ injection. Reconstitution with 1mL of preservative-free Sterile Water for injection is required prior to SubQ administration of the drug, resulting in a total volume of 1.2mL reconstituted solution		
☐ Kineret ®	☐ 100 mg Prefilled Syringe	☐ Inject 100mg (1 syringe) SC QDay	4 week supply	
☐ Orencia ®	☐ 250 mg Vial ☐ 125 mg Orencia SubQ	☐ Infuse __mg in 100mL of 0.9 NaCl at weeks 0, 2, 4, then every 4 weeks ☐ Other_______________________ ☐ After single IV loading dose, inject 125mg SubQ within a day followed by 125mg SubQ injections every week thereafter ☐ For patients unable to receive an IV loading dose, inject 125mg SubQ every week ☐ For patients transitioning from IV infusion therapy to SubQ therapy, inject 125mg SubQ instead of the next scheduled IV dose followed by 125mg SubQ injections every week thereafter	# of vials _______	
☐ Remicade ®	☐ 100 mg Vial Total dose needed______ ______mg/kg	☐ Initial Dose: IV in 250ml of 0.9% NaCl at weeks 0, 2, and 6 weeks (ICD-9: 714.0, 696.0, & 720.0) ☐ Maint. Dose: IV in 250ml of 0.9% NaCl every 8 weeks (ICD-9: 714.0 & 696.0) ☐ Maint. Dose: IV in 250ml of 0.9% NaCl every 6 weeks (ICD-9: 720.0) ☐ Other:____		
☐ Rituxan ®	☐ 100mg/10ml vial ☐ 500mg/50ml vial	☐ Infuse 1000mg in 1 Liter 0.9% NaCl q2weeks x 2 doses ☐ Other:	# of vials	
☐ Simponi®	☐ 50mg/0.5ml SmartJect AutoInjector ☐ 50mg/0.5ml Prefilled Syringe	☐ Inject 50mg SC ONCE a month ☐ Other:___________________	4 week supply Other_____	
☐ Simponi ® ARIA ™	☐ 50mg/4mL vial (12.5mg/mL) in single use vial)	☐ 2mg/kg intravenous infusion over 30 min. at wks 0 and 4, then every 8 wks Dilution of supplied Simpona ARIA solution w/ 0.9% w/v NaCl is required prior to administration		
☐ Stelara ®	☐ Injection 45mg/0.5mL in single-use prefilled syringe ☐ Injection 90mg/mL in single-use prefilled syringe	☐ The recommended dose is 45mg SQ initially and 4 weeks later, followed by 45mg SQ every 12 weeks. For patients w/ co-existent moderate-to-severe plaque psoriasis weighing > 100kg (200lbs), the recommended dose is 90mg initially and 4 weeks later, followed by 90mg every 12 weeks.		
☐ Xeljanz ®	☐ 5 mg	☐ Take one 5 mg tablet PO twice daily	☐ 60 ☐ Other	
☐ Other:____				
☐ Premedication	☐ Diphenhydramine (Benadryl®) 25mg Orally 30 minutes before infusion OR other dose ___________________________________ ☐ Acetaminophen (Tylenol®) 650mg Orally 30 minutes before infusion OR other dose _____________________________________ ☐ Methylprednisolone (Soul-Medrol®) 60mg IV ☐ Prednisone 40mg Orally ☐ Epinephrine (1;1000) 0.3ml SC for anaphylactic reaction and contact physician ☐ Supplies needed (syringes/needles, alcohol, sharps container) ☐ Other:____			

Physician

MD: | License: | DEA #: | NPI #:

Specialty: | Practice: | Email: | Hospital/Clinic:

Phys. Phone: | Phys. Fax: | Address: | Office Contact:

Date Shipment Needed: ____________ Ship To: ☐ Patient ☐ Physician; ☐ Other_________________________ *All the supplies including syringes and needles will be dispensed if requested above.*

☐ Patient is interested in support programs

Physician Signature: ____ Per state law must write out DAW (if applicable): __________________________ Date: ___________

By signing below, I authorize Streamline DBA Decillion Healthcare ("Streamline DBA Decillion Healthcare") to: Collect my health condition and prescription information from my doctor, healthcare provider, health insurer or pharmacist in order to ensure its accuracy and completeness and to communicate to the patient support program of the pharmaceutical manufacturer (the "Program"); and contact my insurer, other potential funding sources, social workers, patient advocacy organizations, and patient assistance programs on my behalf to determine if I am eligible for assistance. I hereby authorize my doctor, healthcare provider, health insurer or pharmacist to provide my health condition and prescription information to Streamline DBA Decillion Healthcare and to the Program. I understand that I may revoke this authorization at anytime by sending a letter to Streamline DBA Decillion Healthcare.

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