



Your Health, True Wealth

Rheumatology Referral Form

Please send the following with clinical documentation, which includes visit, physical and history notes, plus lab results for last 3 months, to:
f: 818-882-8929

PATIENT INFORMATION

Patient Name		DOB		Contact Phone	
Address		City	State		Zip
Gender ☐ M ☐ F	Social Security, last 4 digits		Weight (lb.)		Height (in.)
☐ NKDA		☐ Allergies			
ICD-10 code (required)			ICD-10 description		
Patient Status ☐ New to Therapy ☐ Continuing Therapy			TB Skin Test ☐ Yes ☐ No	Hepatitis B Screen ☐ Yes ☐ No	

PRESCRIBER INFORMATION

Ordering Prescriber		Prescriber NPI	
Practice Name		Phone	Fax
Practice Address		City	State Zip

REQUIRED DOCUMENTATION

☐ Insurance Cards	☐ History & Physical	☐ Most Recent Labs	☐ Medication List
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RHEUMATOLOGY TREATMENT PLAN

☐ Remicade® or Biosimilar _____ Loading dose: ☐ 5mg/kg ☐ 7.5mg/kg ☐ 10mg/kg at 0, 2 and 6 weeks, then every _____ weeks thereafter	
☐ Rituxan® or Biosimilar _____ ☐ 500mg ☐ 1000mg ☐ Administer IV at day 1, then at day 15. Administer every _____ months thereafter	
☐ Krystexxa® 8mg/250ml 0.9% sodium chloride or 0.45% sodium chloride every 2 weeks	
☐ Simponi Aria® 2mg/kg IV infusion over 30 min, then at week 4 and then every 8 weeks thereafter	
☐ Stelara® ☐ 45mg subcutaneously at initial, and week 4. Followed by 45mg subcutaneously every 12 weeks after (patients < 100kg) ☐ 90mg subcutaneously at initial, and week 4. Followed by 90mg subcutaneously every 12 weeks after (patients > 100kg)	
☐ Skyrizi® ☐ Loading Doses - Inject 150 mg SC at weeks 0 and 4 ☐ Maintenance Dose - Inject 150 mg SC every 12 weeks thereafter	☐ Tremfya® ☐ Loading Doses - Inject 100 mg SC weeks 0 and 4 ☐ Maintenance Dose - Inject 100 mg SC every 8 weeks thereafter
☐ Other	Include dosage, frequency and any other special instructions.
☐ Refill for 1 year	

NURSING

Skilled RN to establish and maintain vascular access as needed, draw ordered labs, conduct patient assessments, and educate on home infusion, medication administration, self-monitoring and safety.

PREMEDICATION

☐ Include premedication per Northridge Pharmacy Specialty & Infusion's infusion protocol.
☐ Other _____

LABORATORY ORDERS

☐ CBC every _____
☐ CMP every _____
☐ Other _____

I authorize the above patient treatment and Northridge Pharmacy Specialty & Infusion to serve as my agent when investigating and seeking approval of coverage and benefits for the Patient's services included in this form, including all site of service options and patient financial responsibility amounts. Such information may be provided to Northridge Pharmacy Specialty & Infusion at fax: 818-882-8929

Prescriber Name (Print)

Prescriber Signature

Date