RHEUMATOLOGY INFUSION REFERRAL FORM

Community Consultant Contact:

Fax referral to: 844-814-1944 Phone: 844-814-1943
Email referral form to: connect@realospecialtycare.com
For additional forms, visit realospecialtycare.com.

PATIENT INFORMATION

Patient Name: _____ ❑Male ❑Female SS#: _____ DOB: _____
Address: _____ City, State, Zip: _____
Primary Phone: _____ ❑Home ❑Cell ❑Work Alternate Phone: _____ ❑Home ❑Cell ❑Work
Email: _____ Height: _____ Weight: _____
Allergies: _____ Comorbidities: _____

PRESCRIBER INFORMATION

Prescriber Name: _____ Office Contact: _____
Address: _____ City, State, Zip: _____
Phone: _____ Fax: _____
NPI: _____ DEA: _____

SHIPPING INFORMATION

Ship To: ❑Patient ❑Physician/Clinic ❑Realo Location: _____
Date Shipment Needed By: _____ ❑Alternate Location: _____
Shipping Address City, State, Zip

DIAGNOSIS AND CLINICAL INFORMATION (Please fax recent clinical notes, labs, and tests to expedite PA)

Diagnosis: ❑M06.9 Rheumatoid Arthritis ❑L40.50 Psoriatic Arthritis
❑M08.0 Juvenile Idiopathic Arthritis ❑Other: _____
❑M45._____ Ankylosing Spondylitis

Is patiently currently on RA Therapy? ❑yes ❑no Medications: _____ Prior Failed Medications:
TB/PPD test given? ❑yes ❑no Does patient have a latex allergy? ❑yes ❑no

PRESCRIPTION INFORMATION

MEDICATION	DOSE	QUANTITY	REFILL	DIRECTIONS
❑Orencia®	❑250mg vial	_____mg in 250mg increments		❑Infuse _____mg IV at 0, 2, and 4 weeks and every 4 weeks thereafter
❑Remicade®	❑100mg vial	_____mg in 100mg increments		❑Infuse _____mg IV at 0, 2, and 6 weeks and every 8 weeks thereafter
❑Renflexis®	❑100mg vial	_____mg in 100mg increments		❑Infuse _____mg IV at 0, 2, and 6 weeks and every 8 weeks thereafter
❑Inflectra®	❑100mg vial	_____mg in 100mg increments		❑Infuse _____mg IV at 0, 2, and 6 weeks and every 8 weeks thereafter

Prescriber Signature: I authorize Realo Specialty Care Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

Dispense As Written - Signature | Date | Substitution Permissable - Signature | Date

PLEASE FAX COPY OF INSURANCE CARD (FRONT + BACK) AND MEDICATION LIST TO 844-814-1944.