



# Rheumatology Order Form

Specialty-specific infusion order form for rheumatology

**REFERRING PROVIDER**

<b>PROVIDER NAME</b>	<b>NPI</b>	<b>DEA (IF CONTROLLED)</b>	<b>SPECIALTY</b>
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<b>PRACTICE / CLINIC NAME</b>	<b>OFFICE PHONE</b>	<b>OFFICE FAX</b>
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<b>OFFICE CONTACT NAME</b>	<b>CONTACT PHONE</b>	<b>CONTACT EMAIL</b>
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**PATIENT INFORMATION**

<b>PATIENT LAST NAME</b>	<b>FIRST NAME</b>	<b>MIDDLE INITIAL</b>
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<b>DATE OF BIRTH</b>	<b>SEX</b>	<b>PATIENT PHONE</b>	<b>BEST TIME TO CONTACT</b>
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<b>ADDRESS</b>	<b>CITY, STATE, ZIP</b>
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**INSURANCE**

<b>PRIMARY INSURANCE</b>	<b>MEMBER ID</b>	<b>GROUP #</b>
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<b>SECONDARY INSURANCE (IF ANY)</b>	<b>MEMBER ID</b>	<b>GROUP #</b>
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**DIAGNOSIS & CLINICAL JUSTIFICATION**

<b>PRIMARY DIAGNOSIS</b>	<b>ICD-10 CODE</b>
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<b>SECONDARY DIAGNOSIS (IF APPLICABLE)</b>	<b>ICD-10 CODE</b>
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**Common indications for this medication:** *Rheumatoid arthritis (M05–M06), psoriatic arthritis (L40.5x), ankylosing spondylitis (M45), SLE (M32), GCA (M31.6), chronic gout (M10)*

**BRIEF CLINICAL SUMMARY / JUSTIFICATION FOR THERAPY**

**PRIOR THERAPIES TRIED AND OUTCOME**

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**RHEUMATOLOGY MEDICATIONS & MDASH; COMMONLY ORDERED**

*Remicade (infliximab), Rituxan (rituximab), Actemra (tocilizumab), Orencia (abatacept), Krystexxa (pegloticase), Benlysta (belimumab), Cimzia (certolizumab), Simponi Aria (golimumab IV), Saphnelo (anifrolumab)*

**MEDICATION ORDER**

MEDICATION		GENERIC / ALT	STRENGTH / FORMULATION
DOSE	FREQUENCY	DURATION	
ROUTE	PRE-MEDICATIONS (IF ANY)		SPECIAL INSTRUCTIONS
ANTICIPATED START DATE	# OF DOSES AUTHORIZED	SUBSTITUTION ALLOWED (Y/N)	BIOSIMILAR ACCEPTABLE (Y/N)

**REQUIRED LABS & MONITORING**

Check all labs the prescriber requires Arbor to verify before each infusion:

- CBC w/ differential
- Hepatitis B/C panel
- Iron studies (ferritin, TSAT)
- CMP
- TB screen (T-SPOT or QFT)
- Vitamin levels (B12, D, folate)
- Liver function panel
- Pregnancy test (urine)
- Other (specify below)

**OTHER LABS / MONITORING REQUIREMENTS**

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**PRESCRIBER SIGNATURE**

By signing below I certify that this order is medically necessary, that I am the prescribing provider for this patient, and that I have reviewed the patient's clinical history relevant to this therapy. Arbor Infusion Therapy is authorized to coordinate scheduling, prior authorization, and benefits verification on the patient's behalf.

PRESCRIBER SIGNATURE	PRINTED NAME	DATE

*Form code: ARB-ORDER-RHEUMATOLOGY · Submit to Arbor Infusion Therapy by fax to [FAX NUMBER] or via secure portal. Arbor will confirm receipt within one business day and begin prior authorization the same day. Questions: [PHONE] · hello@arborinfuse.com*