

**PATIENT INFORMATION**

Fax completed form, insurance information and clinical documentation to 586-263-3306

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
<b>Actemra</b>	<input type="checkbox"/> 4 mg/kg IV every 4 weeks for _____ doses, then followed by 8mg/kg every 4weeks 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	
<b>Cimzia</b>	<input type="checkbox"/> Initial Dose: 400mg subcutaneously at weeks 0, 2, and 4 weeks Maintenance Dose: <input type="checkbox"/> 200mg subcutaneously Q 2 weeks <b>OR</b> <input type="checkbox"/> 400mg subcutaneously Q 4 weeks	
<b>Krystexxa</b>	<input type="checkbox"/> 8mg IV every 2 weeks	
<b>Immunoglobulin</b>	<input type="checkbox"/> IV <input type="checkbox"/> SubQ _____gm/kg x _____day(s) <b>OR</b> divided over _____day(s) Brand: _____ _____mg/kg x _____day(s) <b>OR</b> divided over _____day(s) (Compassus to choose if not indicated) Frequency: Every _____ weeks or _____	
<b>Orencia</b>	Orencia Dose: _____ mg IV Frequency: <input type="checkbox"/> Every 4 weeks <b>OR</b> <input type="checkbox"/> 0, 2, 4 weeks, and every 4 weeks thereafter	
<b>Simponi Aria</b>	<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	
<b>Stelara</b>	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	
<b>Infliximab</b>	Dose: _____mg/kg <input type="checkbox"/> May substitute biosimilar per insurance requirement Frequency: <input type="checkbox"/> Every _____ weeks For Compassus use Brand: _____ <input type="checkbox"/> 0, 2, 6, then every 8 weeks <input type="checkbox"/> Do not substitute. Brand: _____	
<b>Rituximab</b>	Dose: <input type="checkbox"/> 1000mg <input type="checkbox"/> Other: _____ <input type="checkbox"/> May substitute biosimilar per insurance requirement <input type="checkbox"/> 375mg/m2 For Compassus use Brand: _____ 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: _____	
<b>Saphnelo</b>	<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: \_\_\_\_\_

Opt out of Compassus selecting site of care (if checked, please list site of care) \_\_\_\_\_

**PREFERRED LOCATION**

City: \_\_\_\_\_ State: \_\_\_\_\_

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**COMPREHENSIVE SUPPORT FOR  
RHEUMATOLOGY THERAPY**  
**P: 888-386-0886 | F: 586-263-3306**

### PATIENT INFORMATION

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

### 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 586-263-3306 or call 888-386-0886 for assistance**

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