RHEUMATOLOGY ORDER SET

P: 331-236-0610 | **F:** 331-314-8989

PATIENT INFORMATION

Fax completed form, insurance information, and clinical documentation to 331-314-8989

Name:		DOB:		Gender: □ Female □ Male
Address:		City:	State:	ZIP:
Phone:	Email:	Height:	□inches □ cmWeight:	□lbs. □ kg
Allergies:				
Diagnosis Code ICD-10 (required):		**Diagnosis Description:**		
Patient Status: □ New to Therapy □ Continuing Therapy		Next Treatment Date:		

PHYSICIAN INFORMATION

Prescriber Name:	Phone:	Fax:
Office Contact:		Email:
Address:	City: State:	ZIP:
NPI #: DEA#:		Tax ID:

INSURANCEINFORMATION (or attach copy of cards)

Primary Insurance:	Policy #:	Group #:
Secondary Insurance:	Policy #:	Group #:

PRESCRIPTION INFORMATION (or attach a copy of the prescription)

Drug	Dosing	Refill
Actemra (tocilizumab)	□ 4 mg/kg IV every 4 weeks for _____ doses, then followed by 8mg/kg every 4 weeks thereafter □ 4 mg/kg IV every 4 weeks □ 8 mg/kg IV every 4 weeks □ Other dose: _____ mg IV every 4 weeks ***Dose not to exceed 800mg in RA/CRS*** ***Dose not to exceed 600mg in GCA***	□ x1 year □_____
Cimzia (certolizumab pegol)	□Initial Dose: 400mg SubQ at weeks 0, 2, and 4 weeks Maintenance Dose: □ 200mg SubQ Q 2 weeks **OR** □ 400mg SubQ Q 4 weeks	□ x1 year □_____
Immunoglobulin	□ IV □ SubQ _____ gm/kg x _____ day(s) **OR** divided over ____ day(s) _____ mg/kg x _____ day(s) **OR** divided over ____ day(s) Frequency: Every _____ weeks or _____ Brand: _____ (LIVbetter to choose if not indicated)	□ x1 year □_____
Infliximab	Dose: _____ mg/kg Frequency: □ 0, 2, 6, then every 8 weeks □ Every _____ weeks □ May substitute biosimilar per insurance requirement ***For LIVbetter use***. Brand: _____ □ Do not substitute. Brand: _____	□ x1 year □_____
Krystexxa (pegloticase)	□ 8mg IV every 2 weeks	□ x1 year □ _____
Orencia (abatacept)	Orencia Dose: _____ mg IV Frequency: □ 0, 2, 4 weeks, and every 4 weeks thereafter OR □ Every 4 weeks	□ x1 year □_____
Rituximab	Dose: □ 1000mg □ 375mg/m2 Frequency: □ One tim edose □ Weeklyx4 □ Day 0, repeat dose in 2 weeks Other: _____ □ Maysubstitute biosimilarperinsurancerequirement ***For LIVbetter use***. Brand: _____ □ Do not substitute. Brand: _____	□_____ □Repeat course in 6 months
Saphnelo (anifrolumab)	□ 300mg IV every 4 weeks	□ x1 year □ _____
Simponi Aria (golimumab)	□ Initial Dose: 2mg/kg at weeks 0, 4, and then every 8 weeks □ Maintenance Dose: 2mg/kg every 8 weeks	□ x1 year □_____
Ustekinumab	□ 45mg SubQ initially, 4 weeks later, followed by 45mg every 12 weeks □ 90mg SubQ initially, 4 weeks later, followed by 90mg every 12 weeks □ 45mg SubQ every 12 weeks □ 90mg SubQ every 12 weeks □ May substitute biosimilar per insurance requirement ***For LIVbetter use***. Brand: _____ □ Do not substitute. Brand: _____	□ x1 year □_____

Pre-medication orders: Acetaminophen □ 1000mg □ 500mg PO, please choose one antihistamine (if indicated):
□ Diphenhydramine 25mg PO □ Loratadine 10mg PO □ Cetirizine 10mg PO □ Cetirizine 10mg IVP

Additionalpre-medications: □ Solu-Medrol _____ mg IVP □ Solu-Cortef _____ mg IVP □ Other _____

Laborders: _____ **Lab Frequency:** _____
□Yearly TB QFT □ Baseline HepBcAB total Required labs to be drawn by: □ LIVbetter Infusions □ Referring Provider

As required by your state, Prescriber to check "Dispense as written" or handwrite "Brand Medically Necessary" and sign to prevent generic substitution. □ Dispense as written

By signing this form and utilizing our services, you are authorizing *LIVbetter Infusions.* 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.

Prescriber Signature: X **Date:**

patients@livbetter.care 255 Town Square, Wheaton, IL 60189

COMPREHENSIVE SUPPORT FOR RHEUMATOLOGY THERAPY

PATIENT INFORMATION

Name: DOB:

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & 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)? _____

☐ CRS dx - Has the patient received treatment with a chimeric antigen receptor T cell therapy (i.e., Kymriah, Yescarta) or Blincyto? ☐ 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 wash-out period of _____ weeks prior to starting ordered biologic therapy.

☐ Other medical necessity: _____

REQUIRED PRE-SCREENING

☐ TB screening test completed within 12 months - attach results
Required for: Actemra, Cimzia, infliximab, ustekinumab**,** 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+)