Referring Physician Orders Rev. 07/2025 Please fax completed referral form & all required documents to (833) 786-0025



Definition			PATIENT D	DEMOGRAF	PHICS				
Patient Name:				DOB:	DOB: Phone:				
Address:									
						🗆 lbs 🗆 kg			
/ liergies		INSURANCE INFOR			-				
					n insurance	cara <u>(irontana back</u>).			
*ICD 10 Code Required	For gout flares: Idiopathic gout (M10.00-M10.09), ICD10 Lead-induced gout (M10.10-M10.19), ICD10 Drug-induced gout (M10.20-M10.29), ICD10 Gout d/t renal impairment (M10.30-M10.39), ICD				☐ Juvenile rheumatoid arthritis [SJIA] (M08.20-M08.2A), ICD10 10				
	Other:		, ICD	10					
			INFUSI	ON ORDER	RS				
MEDICATION		DOS	DIRECTIONS/DURATION						
		□ For Gout Flares: 150mg SC injection x 1 dose							
		□ For Still's Disease: mg (4mg/kg; MAXIMUM=300mg) SC injection every 4 weeks x 1 year						year	
Is patient currer another facility?	ntly receiving therapy	y above from	lf yes, Faci	lity Name:					
	ſ	-		treatment: Date of ne					
PRE-MEDICAT									
_				Labs to be d		□ Infusion Center		ing Physician	
•	ordered at this time	C Other			•			ing Fhysician	
	-	Other:		-			_		
□ Diphenhydramine 25mg PO						□ CMP q	⊔ CRP q		
				🗆 ESR q		🗆 LFTs q	Other:		
		REF	ERRING PHY	SICIAN INF	ORMAT	ION			
Physician Signati	ure:			SICIAN INF	ORMAT				
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Physician Name: Address:			NPI:	SICIAN INF	City/ST/Zip	TION Date: Specialty:			
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