



# Rheumatology & Dermatology Referral

BIOMED Pharmaceuticals

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San Antonio  
211 North San Saba, Suite 205  
San Antonio, TX 78207

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_

Parent or Guardian: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ St. \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Male \_\_\_ Female \_\_\_

Emergency Contact Name \_\_\_\_\_ Relationship \_\_\_\_\_

Emergency Contact Phone # \_\_\_\_\_ Primary Language \_\_\_\_\_

Primary Insurance: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_

Phone #: \_\_\_\_\_

Phone #: \_\_\_\_\_

Subscriber: \_\_\_\_\_ DOB: \_\_\_\_\_

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ID#: \_\_\_\_\_ Policy/Group #: \_\_\_\_\_

ID#: \_\_\_\_\_ Policy/Group #: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer \_\_\_\_\_

Prescription Drug Card: Name \_\_\_\_\_ Group# \_\_\_\_\_ ID# \_\_\_\_\_

### Diagnosis:

- 714.0 Rheumatoid Arthritis
- 714.2 Other RA with visceral or systemic involvement
- 696.0 Psoriatic Arthritis
- 720.0 Ankylosing Spondylitis
- Other: \_\_\_\_\_

Complicating Factors: \_\_\_\_\_

Is the Patient Currently on any medications? \_\_\_yes \_\_\_no

List medications: \_\_\_\_\_

ALLERGIES: \_\_\_\_\_ Patient Weight: \_\_\_\_\_

### Prescription:

\_\_\_ Remicade 3 mg/kg or \_\_\_ Remicade 5 mg/kg IV titrate per protocol over 2-3 hours  
Infuse Remicade in 250 ml 0.9% NS using non-PVC tubing and 1.2 micron filter via PIV.

### Premedication Orders:

Benedryl 25 / 50 mg PO / IV Tylenol \_\_\_\_\_ mg PO  
Solu-medrol \_\_\_\_\_ mg IV

- PPD Test Prior to infusion
- Anaphylaxis Kit per protocol
- Sterile water for injection and related supplies
- 5-10 ml 0.9% NS for flush as needed

Other: \_\_\_\_\_

\*Anaphylaxis order:

Benadryl 50 mg/IV 25 mg/min (dose 1-2 mg/kg-max 300 mg); Solumedrol 125 mg IV (dose 4-8 mg/kg max 400 mg); Epinephrine 1:1000 (1 mg/ml) 0.3 ml IM or SQ (0.01 ml/kg/dose max 0.3 ml) may repeat 5-10 min.

Physician Certification: \_\_\_\_\_ TPI # \_\_\_\_\_ UPIN# \_\_\_\_\_ Tax ID# \_\_\_\_\_

Signature: \_\_\_\_\_ Date \_\_\_\_\_

Print Name: \_\_\_\_\_ DEA # \_\_\_\_\_ NPI# \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Thank you for your referral.



**Please send front and back copies of all insurance cards with referral.**