Initial Order: ❑

Patient Name: _____ DOB: _____

Diagnosis: _____ ICD−10 Code: _____

Date Diagnosed: _____ Diagnosing Physician: _____

Secondary Dx _____ ICD−10 Code: _____

Date Diagnosed: _____ Diagnosing Physician: _____

If other than present prescribing Physician, were notes requested? ❑ Y ❑ N

Date: _____

Requested from: _____

Quantiferon Gold TB test ❑ Date: _____ TB Skin test: ❑ Date: _____

Initial Diagnosis Date _____ Supporting labs and X−rays: ❑

Supporting Dr's Note: ❑

DMARDS

Has patient tried any of the following?

Methotrexate:	❑ Y	❑ N	Date Started_____	Date Stopped_____
Plaquenil:	❑ Y	❑ N	Date Started_____	Date Stopped_____
Arrava:	❑ Y	❑ N	Date Started_____	Date Stopped_____
Sulfasalazine:	❑ Y	❑ N	Date Started_____	Date Stopped_____
Imuran:	❑ Y	❑ N	Date Started_____	Date Stopped_____
Other:_____	❑ Y	❑ N		

Contraindications: _____

_____

Biologic:

1st Tier:

Enbrel:	❑ Y	❑ N	Date Started_____	Date Stopped_____
Humira:	❑ Y	❑ N	Date Started_____	Date Stopped_____
Xeljanz:	❑ Y	❑ N	Date Started_____	Date Stopped_____
Other:_____	❑ Y	❑ N	Date Started_____	Date Stopped_____

Contraindications: _____

_____

Infusion:

Remicade:	❑ Y	❑ N	Date Started_____	Date Stopped_____
Orencia	❑ Y	❑ N	Date Started_____	Date Stopped_____
Actemra:	❑ Y	❑ N	Date Started_____	Date Stopped_____
Stellara	❑ Y	❑ N	Date Started_____	Date Stopped_____
Rituxan:	❑ Y	❑ N	Date Started_____	Date Stopped_____
Cimzia:	❑ Y	❑ N	Date Started_____	Date Stopped_____
Simponi Aria:	❑ Y	❑ N	Date Started_____	Date Stopped_____
Other: _____	❑ Y	❑ N	Date Started_____	Date Stopped_____

Contraindications: _____

_____

Please FAX this completed form along with Diagnostic, and Decision for Infusion Office Note to ITC at 603.740.2838.

_____ _____

Physician Signature **Date / Time**