



2301 Evesham Road - Building 800, Suite 115 Voorhees, New Jersey 08043 T. (856) 996-0145 F. (609) 751-9799

MEDICATION REQUESTED

DATE:

NAME OF DRUG BEING REQUESTED: IDYLLIC will be responsible for providing requested drug

REFERRING PROVIDER INFORMATION

Requesting Provider Name and NPI Tax ID#	Name: NPI #: Tax ID #:	
Phone Number		
Fax Number		
Practice Contact (Name/Extension)	Phone Number:	Ext:

We will gladly remind your patient to schedule routine follow-up visits with your office.

Return	to	Referring	Provider	(frequency):	EVERY		WKS	/	MOS
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PATIENT INFORMATION Patient Name Patient Address: City, State, Zip Phone (Mobile) Date of Birth / Patient Allergies Height / Weight





Preferred Treatment Location	⊠ Voorhees ⊠ Wall/Manasquan ⊠ Hamilton	⊠ Moorestown ⊠ Sewell ⊠ Galloway
Primary Care Physician (Name / Phone Number)	PCP Name:	
	PCP Phone Number:	

ADDITIONAL DOCUMENTATION REQUIRED

\square	Primary	Diagnosis	code.
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- Please attach a copy of medication order to this document when transmitting to ARBDA/IDYLLIC. Prescription should include standard information as well as specific instructions if loading doses of desired RX are required. ** NOTE ** Please do NOT provide a prescription to the patient as they may become confused and attempt to fill at their local/specialty pharmacy.
- □ Copy of Primary and Secondary Medical/Pharmacy Insurance Cards (Please enclose both FRONT & BACK)
- □ Is this patient ambulatory? Yes / NO
 □ Is a wheelchair required Yes / NO
- □ History of Infusion / Injection treatments (if applicable) and summary of medical history / treatment plan.
- □ MOST RECENT and/or Qualifying Labs (based on specific drug)
- □ Verification that the patient was issued a RX by the referring provider for an EpiPen and that patient was instructed to bring the EpiPen with them to the injection/infusion appointment (if required).
- Please notify your patient that our office will contact them when we are ready to schedule. They do NOT need to call our office to set up an appointment.
- Does this patient require premedication(s)? If so, please indicate below:
 - □ TYLENOL[®] (APAP) 500 mg. tablets 2 tabs PO x 1
 - □ SOLU-MEDROL[®] (or equivalent glucocorticoid) 100 mg. IVP x1
 - □ ZYRTEC[®] (cetirizine) 10 mg. Tablets 1 tab PO x 1
 - □ Other: _____

PLEASE NOTE: OUR OFFICE PROVIDE & DISPENSE ALL REQUIRED MEDICATIONSARBDA/IDYLLIC NPI: 1427622661TAX ID: 85-1604336

Please contact our office if medication will be discontinued.





1) Medication being requested: Infliximab Simponi Aria Orencia □ Actemra □ Rituximab Benlysta Dose/Frequency: 2) Have all required labs been completed in the past 6 months: 🖵 YES □ NO (Patient provided with lab order; labs pending) **Copies of labs are required*** 3) Disease with ICD-10: □ M05.79 (RF+RA) □ M06.09 (RF-RA) □ M32.9 (Lupus) □ L40.59 (PsA) □ L40.0 (Psoriasis) □ M45.7 (Ank.Spond-lumbosacral) □ M31.31 (GPA w/Renal) □ M31.30 (GPA w/o Renal) □ M31.7 (MPA) 4)If PsA, Axial Disease? 🖵 YES 📮 NO 5) TB test performed? 🖸 YES 📮 NO 📮 Pending Date? : Result?: D Positive D Negative 6)Hepatitis B/C testing performed? : 🖵 YES 📮 NO Pending 7) Has the patient been diagnosed with lymphoma or skin cancer? YES NO 8)Does the patient have an infection? 🖵 YES 🗳 NO





9) Does the patient have CHF? 🗖 YES 📮 NO
10)Inadequate response to NSAIDs? YES NO
11)Has the patient tried and failed a DMARD/biologic for 8-12 weeks)?
a.DMARDs tried and failed: 🖵 methotrexate 📮 leflunomide □ other:
12)Contraindications to DMARDs? 🖬 Yes 📮 NO If yes, list:
13)Will this be used in combo with methotrexate or another DMARD?
If yes, list: 🗖 methotrexate 🗖 leflunomide 📮 sulfasalazine 📮 hydroxychloroquine
14)For Benlysta Only: dsDNA Positive? • YES • NO SLEDAI :

Additional Comments: