RA & INFLAMMATION (A-L) REFERRAL FORM

Updated Dec 2019

Patient Name _____ Today's Date_____ ☐ *NEW* Patient ☐ *CURRENT Patient*
DOB _____ Height _____ Weight _____ ☐ Male ☐ Female Preferred Language _____
Best Phone _____ Email _____
Street Address _____ Apt#_____ City _____ State _____ Zip _____
Ship to Patient at: ☐ Home ☐ Physician Office ☐ Work Address _____
Allergies _____
Current Medications including OTC's (*please fax a complete list*) _____

Please Fax Insurance Card(s) both sides
Insured's Name _____
Relation to Patient _____
Primary Insurance _____
ID# _____ Group # _____
Secondary Insurance _____
ID# _____ Group # _____

Ordering Prescriber _____
Office Contact _____
Street Address _____ Suite #_____
City _____ State _____ Zip _____
Tel _____ Fax _____
Email _____
License# _____
NPI# _____

ICD-10 Code ☐ **M06.9** Rheumatoid Arthritis ☐ **L40.59** Psoriatic Arthritis ☐ **M45.9** Ankylosing Spondylitis
PPD (TB Test) _____ Chest X-ray _____ Date of Labs_____ ☐ Rheumatoid Factor + Total Swollen Joints ____
☐ **Yes** ☐ **No** Previously treated? If Yes, what drugs _____

PRESCRIPTION

☐ **ACTEMRA®** (tocilizumab) **Prefilled-Syringe**
SIG: ☐ Inject 162 mg subcutaneously every other week (pt wt<100kg) QTY:_____ Refill: _____
☐ Inject 162 mg subcutaneously every week (pt wt >100kg or per clinical response) QTY:_____ Refill: _____
☐ **ACTEMRA IV** _____mg Q4W (every 4 weeks) Adult (IV) Dosage
SIG: starting dose is 4 mg/kg every 4 weeks followed by an increase to 8 mg/kg every 4 weeks based on clinical response QTY:_____ Refill: _____

☐ **CIMZIA 200mg** ☐ **PFS** ☐ **SD Vial**
SIG: ☐ **Starting dose:** 400 mg subcutaneously initially and at weeks 0,2, & 4 QTY: 1 Starter Kit Refill: _____
☐ **Maintenance dose:** 200 mg subcutaneously every other weeks QTY: 28 Day Supply Refill: _____
☐ Other: _____ QTY:_____ Refill: _____

☐ **COSENTYX** *Psoriatic Arthritis & Ankylosing Spondylitis only* ***New York Prescribers, please submit prescription on an original NY State prescription blank.***
With Loading Dose: ☐ **Sensoready® Pen** ☐ **Prefilled Syringe** *Weeks 0, 1, 2, 3, and 4, then once every 4 weeks*
SIG: ☐ Inject 150 mg dose subcutaneously once weekly for 5 weeks QTY: 10 injection devices Refills: 0
Without Loading Dose: ☐ **Sensoready® Pen** ☐ **Prefilled Syringe**
SIG: ☐ Inject 150 mg dose subcutaneously once every 4 weeks
☐ 1 Month ☐ 2 Months ☐ 3 Months QTY:_____ Refill: _____

☐ **ENBREL®** ☐ **50 mg** ☐ **25 mg** | ☐ **SureClick™** ☐ **Prefilled Syringe** ☐ **Multiuse Vial** ☐ **Enbrel Mini™/AutoTouch**
Dispense/Sig: ☐ 1 x week ☐ 2 x week QTY: 28 Day Supply Refill: _____

☐ **FORTEO®** (#1 pen) ☐ Inject 20 mg subcutaneously daily QTY: 1 pen w/30 needles Refill: _____
PEN NEEDLES ☐ 31 gauge-5 mm use with forteo as directed QTY: 30 Refill: _____
☐ 32 gauge-4 mm use with forteo as directed QTY: 30 Refill: _____

Rheumatoid Arthritis, Ankylosing Spondylitis, Psoriatic Arthritis Patient weight (kg)_____
☐ **HUMIRA 40 mg/0.8mL** ☐ **PFS** ☐ **Pens** ☐ **HUMIRA CITRATE-FREE 40 mg/0.4mL** | ☐ **PFS** ☐ **Pens**
SIG: ☐ Inject 40 mg subcutaneously every other week QTY: 28 Day Supply Refill: _____

Polyarticular JIA ☐ **HUMIRA** ☐ **10 mg/0.1** ☐ **20 mg/0.2 mL** ☐ **40 mg/0.4 mL** | ☐ **PFS** ☐ **Pens**
☐ **HUMIRA Citrate-Free** ☐ **10 mg/0.1** ☐ **20 mg/0.2 mL** ☐ **40 mg/0.4 mL** | ☐ **PFS** ☐ **Pens**

☐ **10 kg (22 lbs) to <15 kg (33 lbs)**	SIG: Inject one 10 mg subcutaneous injection QOW	QTY:_____	Refill: _____
☐ **15 kg (33 lbs) to <30 kg (66 lbs)**	SIG: Inject one 20 mg subcutaneous injection QOW	QTY:_____	Refill: _____
☐ **≥30 kg (66 lbs)**	SIG: Inject one 40 mg subcutaneous injection QOW	QTY:_____	Refill: _____

☐ **ENROLL IN NURSE TRAINING / MANUFACTURER PROGRAM**

Prescriber's Signature (signature required. NO STAMPS)_____ **Date** _____

My signature certifies that the person named on this form is my patient and that the information provided on this enrollment form is complete and accurate to the best of my knowledge. I certify this therapy to be medically necessary.
My signature authorizes The Pharmacy and its representatives to act as the agent to execute the insurance prior authorization process, assist the above named patient enroll into patient support programs, and appeal on behalf of prescriber and patient in the event of a prior authorization denial.

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.
PLEASE NOTE: The Pharmacy can only accept original prescription drug orders from patients, faxed prescriptions can be accepted only from the prescribing practitioners.

RA & INFLAMMATION (M-Z) REFERRAL FORM

Updated Dec 2019

Patient Name _____ Today's Date_____ ☐ *NEW* Patient ☐ *CURRENT Patient*
DOB _____ Height _____ Weight _____ ☐ Male ☐ Female Preferred Language _____
Best Phone _____ Email _____
Street Address _____ Apt#_____ City _____ State _____ Zip _____
Ship to Patient at: ☐ Home ☐ Physician Office ☐ Work Address _____
Allergies _____
Current Medications including OTC's (*please fax a complete list*) _____

Please Fax Insurance Card(s) both sides
Insured's Name _____
Relation to Patient _____
Primary Insurance _____
ID# _____ Group # _____
Secondary Insurance _____
ID# _____ Group # _____

Ordering Prescriber _____
Office Contact _____
Street Address _____ Suite #_____
City _____ State _____ Zip _____
Tel _____ Fax _____
Email _____
License# _____
NPI# _____

ICD-10 Code ☐ **M06.9** Rheumatoid Arthritis ☐ **L40.59** Psoriatic Arthritis ☐ **M45.9** Ankylosing Spondylitis
PPD (TB Test) _____ Chest X-ray _____ Date of Labs_____ ☐ Rheumatoid Factor + Total Swollen Joints _____
☐ **Yes** ☐ **No** Previously treated? If Yes, what drugs _____

PRESCRIPTION

☐ **METHOTREXATE VIALS**
☐ **RASUVO** ☐ **OTREXUP**
SIG: ☐ Inject ____mg subcutaneously once weekly QTY:_____ Refill: _____
SIG: ☐ Take ____mg tablets by mouth once weekly QTY:_____ Refill: _____
SIG: ☐ Other:_____ QTY:_____ Refill: _____

☐ **KEVZARA®** ☐ **200 mg/1.14 mL single dose PFS** | ☐ **150 mg/1.14 mL single dose PFS**
Dispense: ☐ Inject 150 mg subcutaneously once every two weeks QTY: 2 Refill: _____
☐ Inject 200 mg subcutaneously once every two weeks QTY: 2 Refill: _____

☐ **OLUMIANT** SIG: 2 mg PO once daily with or without food QTY: 30 Refill: _____

☐ **ORENCIA®** ☐ **125mg PFS** ☐ **250 mg Vial** ☐ **125 mg ClickJect™ (Carton of 4 Autoinjectors)**
Dispense: ☐ Inject 125 mg subcutaneously weekly **OR** ☐ 250 mg Vial (IV use only) QTY: 28 day supply Refill: _____
Loading Dose: 10mg/kg IV x 1 dose, then 125 mg subcutaneously weekly, start within 24 hours of IV dose, 1 dose, 4 week supply

☐ **OTEZLA®** SIG: ☐ Titration Starter Pack SIG: Take as directed QTY: 55 for 28 days
☐ Maintenance: 30 mg SIG: Take 30 mg twice a day QTY: 60 Refill: _____

☐ **RINVOQ™ 15mg** tablet SIG: Take one tablet by mouth once daily QTY: 30 Refill: _____

☐ **STELARA**
☐ **45 mg** ☐ **90mg**
☐ **Start Dose:** Inject ____ mg subcutaneously initially and 4 weeks later QTY: 2 Refill: _____
☐ **Maintenance Dose:** Inject ____ mg subcutaneously every 12 weeks QTY: 1 Refill: _____

☐ **SIMPONI®** ☐ **SureJect™ 50mg/0.5mL** ☐ **PFS 50mg/0.5mL** SIG: Inject 50 mg subcutaneously once per month QTY: 1 Refill: _____
☐ **SIMPONI ARIA® 50 mg/4 mL (12.5 mg/mL) in a single use vial**
SIG: 2 mg/kg intravenous infusion over 30 minutes at weeks 0 and 4, then every 8 weeks QTY: 1 Refill: _____

☐ **TALTZ 80mg/mL** ☐ **Autoinjector** ☐ **Prefilled Syringe**
Psoriatic Arthritis ☐ **Start Dose:** Inject 160 mg subcutaneously at week 0 QTY: 2 Refill: _____
☐ **Maintenance Dose:** Inject 80 mg subcutaneously every 4 weeks QTY:_____ Refill: _____

☐ **XELJANZ® 5 mg tablet** ☐ **XELJANZ XR® 11 mg tablet**
Rheumatoid Arthritis ☐ 5 mg twice daily ☐ 11 mg once daily
Psoriatic Arthritis ☐ 5 mg twice daily, used in combination with nonbiologic DMARDs QTY:_____ Refill: _____
☐ 11 mg once daily, used in combination with nonbiologic DMARDs QTY:_____ Refill: _____
☐ Other: _____ QTY:_____ Refill: _____

☐ **ENROLL IN NURSE TRAINING / MANUFACTURER PROGRAM**

Prescriber's Signature (signature required. NO STAMPS)_____ **Date** _____

My signature certifies that the person named on this form is my patient and that the information provided on this enrollment form is complete and accurate to the best of my knowledge. I certify this therapy to be medically necessary.
My signature authorizes The Pharmacy and its representatives to act as the agent to execute the insurance prior authorization process, assist the above named patient enroll into patient support programs, and appeal on behalf of prescriber and patient in the event of a prior authorization denial.

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PLEASE NOTE: The Pharmacy can only accept original prescription drug orders from patients, faxed prescriptions can be accepted only from the prescribing practitioners.