Faxed prescriptions will only be accepted from an authorized prescriber. Prescribers are reminded patients may choose any pharmacy of their choice

Rheumatology Referral Form

1. Patient Information

Patient Name: Birthdate: Sex: ☐ Male ☐ Female Weight ☐ lbs. ☐ kg

Preferred Phone: Known Allergies

Address: City: State Zip:

***Insurance Information: Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical) ***

2. Prescriber Information

Prescriber Name: NPI# Tax ID#

Address: Phone: Fax:

City, State, Zip: Key Contact:

3. Diagnosis/Clinical Information

Diagnosis: ICD-10

Prior Failed Medications: (medication and duration of treatment/reason for d/c)

☐ NSAID ☐ COX-2 ☐ sulfasalazine ☐ cyclosporine

☐ corticosteroids ☐ leflunomide ☐ methotrexate ☐ hydroxychloroquine

☐ Other DMARD: ☐ JAK Inhibitor ☐ TNF Inhibitor

☐ Other Biologic:

Dates Used

_____

Reason for D/C:

Is the Patient currently receiving other immunosuppressive therapy?

☐ Yes:

☐ No

Other notes:

Quantiferon TB Status: ☐ Positive ☐ Negative ☐ Pending

Please FAX recent clinical notes, labs, and tests with the prescription to expedite the Prior Authorization

4. Prescription Information

Medication	Dose/Strength	Sig	QTY.	Refills
☐ Actemra®	☐ 162/0.9 ml PFS	☐ Inject 162 mg SC every OTHER week ☐ Inject 162 mg SC ONCE a week	___Week Supply	_____
☐ Benlysta®	☐ 200 mg/1ml autoinjector ☐ 200 mg/1ml PFS	☐ Inject 200 mg SC ONCE weekly	___Week Supply	_____
☐ Bimzelx®	☐ 160 mg/1ml prefilled autoinjector ☐ 160 mg/1ml PFS ☐ 320 mg/2ml prefilled autoinjector ☐ 320 mg/2ml PFS	☐ Inject 160 mg SC every 4 weeks ☐ Inject 320 mg SC _____	___Week Supply	_____
☐ Cimzia®	☐ 200 mg/1ml PFS	☐ **Starter Dose:** Inject 400 mg SC at weeks 0, 2, and 4 ☐ **Maintenance Dose:** Inject 2 PFS SQ every 4 weeks or Inject 1 PFS every 2 weeks	___Week Supply	_____
☐ Cosentyx®	☐ 150 mg1/ml Sensoready pen ☐ 150 mg/1ml PFS ☐ 300 mg/2ml UnoReady pen ☐ 300 mg/2ml PFS	☐ **Starter Dose:** 150 mg SC at weeks 0, 1, 2, 3, and 4 ☐ **Maintenance Dose:** Inject 150 mg SC every 4 weeks ☐ **Starter Dose:** 300 mg SC at weeks 0, 1, 2, 3, and 4 ☐ **Maintenance Dose:** Inject 300 mg SC every 4 weeks ☐ Other Dose Schedule: _____	___Week Supply	_____
☐ Enbrel®	☐ 50 mg/1ml PFS ☐ 50 mg/1ml SureClick™ autoinjector ☐ 50 mg1/ml Mini™ With AutoTouch™ ☐ 25 mg/0.5ml PFS	☐ Inject 50 mg SC ONCE a week ☐ Other: _____	___Week Supply	_____
☐ Folic acid	☐ 400 mcg ☐ 800 mcg ☐ 1 mg	☐ Take _____tablets by mouth daily	___Week Supply	_____
☐ Humira®	☐ 40 mg/0.4ml Citrate Free PFS ☐ 40 mg/0.4ml Citrate Free Pen	☐ Inject 40 mg SC every OTHER week ☐ Inject 40 mg SC ONCE a week ☐ Other: _____	___Week Supply	_____
☐ Ilumya®	☐ 100 mg/1ml PFS	☐ Inject 100 mg SC at weeks 0,4, and every 12 weeks thereafter	___Week Supply	_____
☐ Kevzara®	☐ 150 mg/1.14ml PFS ☐ 200 mg/1.14ml PFS ☐ 150 mg/1.14ml Pen ☐ 200 mg/1.14ml Pen	☐ Inject 200 mg SC once every 2 weeks ☐ Other: _____	___Week Supply	_____
☐ Methotrexate	☐ 2.5 mg	☐ Take _____tablets by mouth weekly	___Week Supply	_____

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Medication	Dose/Strength		Sig	QTY.	Refills
☐ Olumiant®	☐ 2 mg tablets ☐ 1 mg tablets		☐ Take 1 tablet ONCE daily	___Week Supply	_____
☐ Orencia®	☐ 125 mg/mL ClickJect™ ☐ 125 mg/mL PFS		☐ Inject 125 mg SC once weekly	___Week Supply	_____
☐ Otezla®	☐ Starter Pack ☐ 30 mg tablets		☐ **Starter Dose:** 28 Days as directed (follow package directions) ☐ **Maintenance Dose:** Take 1 tablet twice daily	___Week Supply	_____
☐ Otrexup®	☐ 10 mg/0.4 mL ☐ 12.5 mg/0.4 mL ☐ 15 mg/0.4 mL ☐ 17.5 mg/0.4 mL	☐ 20 mg/0.4 mL ☐ 22.5 mg/0.4 mL ☐ 25 mg/0.4 mL	☐ Inject _____SC once weekly	___Week Supply	_____
☐ Rasuvo®	☐ 7.5 mg/0.15mL ☐ 10 mg/0.2mL ☐ 12.5 mg/0.25mL ☐ 15 mg/0.30mL ☐ 17.5 mg/0.35mL	☐ 20 mg/0.4ml ☐ 22.5 mg/0.45mL ☐ 25 mg/0.5mL ☐ 27.5 mg/0.55mL ☐ 30 mg/0.6mL	☐ Inject _____SC once weekly	___Week Supply	_____
☐ Rayos®	☐ 1 mg delayed-release tablets ☐ 2 mg Delayed-release tablets ☐ 5 mg Delayed-release tablets		☐ Take ____ tablets ____ times per day by mouth with food	___Week Supply	_____
☐ Rinvoq®	☐ 15 mg tablets		☐ Take 1 tablet by mouth daily	___Week Supply	_____
☐ Simponi®	☐ 50 mg PFS ☐ 50 mg SmartJect® ☐ 100 mg SmartJect® ☐ 100 mg PFS		☐ Inject 50 mg SC every 4 weeks ☐ Other:_____	___Week Supply	_____
☐ Skyrizi®	☐ 150 mg/1ml single dose prefilled pen ☐ 150 mg/1ml PFS		☐ Inject 150 mg SC at week 0, week 4, and every 12 weeks thereafter	___Week Supply	_____
☐ Stelara®	☐ 45 mg/0.5ml PFS ☐ 90 mg/1ml PFS		☐ **Starter Dose:** Inject_____SC weeks 0 and 4 ☐ **Maintenance Dose:** Inject _____ SC every 12 weeks	___Week Supply	_____
☐ Taltz®	☐ 80 mg/mL single-dose prefilled Autoinjector ☐ 80 mg/mL single-dose PFS		☐ **Starter Dose:** Inject 160 mg SC at week 0; _____ ☐ **Maintenance Dose:** 80mg SQ _____ ☐ Other Dose Schedule:_____	___Week Supply	_____
☐ Tremfya®	☐ 100 mg/1ml One-Press Patient controlled injector ☐ 100 mg/1ml prefilled pen ☐ 100 mg/1ml PFS		☐ Inject 100 mg by SC at week 0, week 4, and every 8 weeks thereafter	___Week Supply	_____
☐ Xeljanz®	☐ 5 mg tablets ☐ 11mg XR tablets		☐ Take 1 tablet by mouth TWICE daily ☐ Take 1 tablet by mouth daily	___Week Supply	_____
☐ Other:				___Week Supply	_____

Dispensing Options: ☐ Pick-Up | Deliver To: ☐Patient's Home ☐ Prescriber's Office

Prescriber Signature: Prescriber, please sign and date below	
	Date

I authorize Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.