Subcutaneous Methotrexate Referral Form

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

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 ☐ azathioprine ☐ cyclosporine
☐ leflunomide ☐ COX-2 ☐ corticosteroids
☐ oral methotrexate ☐ TNF inhibitor
Is the Patient receiving other immunosuppressive therapy?
☐ No ☐ Yes: ____

Highest Tolerated oral MTX dose: ____________________________________
Where side effects dose limiting ☐ Yes ☐ No
What Side effects: ____

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
☐ Methotrexate Tablet	☐ 2.5mg	☐ Take __________tables by mouth weekly	QS	
☐ Folic acid	☐ 400 mcg ☐ 800 mcg ☐ 1 mg	☐ Take __________tables by mouth daily	QS	
☐ Evergreen Pharmacy Subcutaneous Methotrexate Protocol™	☐ 7.5 mg ☐ 17.5 mg ☐ 10 mg ☐ 20 mg ☐ 12.5 mg ☐ 22.5 mg ☐ 15mg ☐ 25 mg ☐ Other_________________________	☐ Inject __________SC as directed daily	QS (28 days)	
☐ Other ________________				

5. Pharmacy Use Only

Selected Medication	Notes
☐ Methotrexate SC Vial/Syringe	
☐ Otrexup®	
☐ Rasuvo®	

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.

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do 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.