Rheumatology 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 ☐ 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
☐ Methotrexate	☐ 2.5 mg	☐ Take __________tablets by mouth weekly	4-week Supply	
☐ Folic acid	☐ 400 mcg ☐ 800 mcg ☐ 1 mg	☐ Take __________tablets by mouth daily	4-week Supply	
☐ Actemra®	☐ 162/0.9 ml PFS	☐ Inject 162 mg SC every OTHER week ☐ Inject 162 mg SC ONCE a week	4-week Supply	
☐ Benlysta®	☐ 200 mg/ autoinjector ☐ 200 mg/mL PFS	☐ Inject 200 mg SC ONCE weekly	4-week Supply	
☐ Cosentyx®	☐ 150 mg/mL PFS ☐ 150 mg/mL Sensoready Pen	☐ **Starter Dose:** 150 mg by SC at weeks 0, 1, 2, 3, and 4 ☐ **Maintenance Dose:** Inject 150 mg by SC every 4 weeks ☐ **Starter Dose:** 300 mg by SC at weeks 0, 1, 2, 3, and 4 ☐ **Maintenance Dose:** Inject 300 mg by SC every 4 weeks	4-Week Supply	0 _____
☐ Cimzia®	☐ 200 mg/ml 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	4-Week Supply	0 _____
☐ Duexis®	☐ ibuprofen 800 mg & famotidine 26.6 mg	☐ Take 1 tablet by mouth 3 times daily ☐ Other: ______________________________	4-week Supply	
☐ Enbrel®	☐ 50 mg/ml PFS ☐ 50 mg/ml SureClick™ autoinjector ☐ 50 mg/ml Mini™ With AutoTouch™ ☐ 25 mg/0.5ml PFS	☐ Inject 50 mg SC ONCE a week ☐ Other: ______________________________	4-week Supply	
☐ Evenity®	☐ 105 mg/1.17mL PFS	☐ Inject 2 separate injections (105 mg each) for a total dose of 210 mg once monthly (injection should be administered by a health-care provider)	4-week Supply	
☐ Forteo®	☐ 2.4 mL PFS	☐ Inject 20 mcg SC as directed daily ☐ Pen needles for injection	4-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: ______________________________	4-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: ______________________________	4-week Supply	

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

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☐ Ilaris®	☐ 150 mg/ml	☐ Inject 150 mg SC every 8 weeks ☐ Other: ______	4-week Supply	
☐ Olumiant®	☐ 2 mg tablets ☐ 1 mg tablets	☐ Take 1 tablet ONCE daily	4-week Supply	
☐ Orencia®	☐ 125 mg/mL ClickJect™ ☐ 125 mg/mL PFS	☐ Inject 125 mg SC once weekly	4-week Supply	
☐ Otezla®	☐ Starter Pack ☐ 30 mg tablets	☐ **Starter Dose:** 28 Days as directed (follow package directions) ☐ **Maintenance Dose:** Take 1 tablet twice daily	4-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	4-week Supply	
☐ Pennsaid®	☐ diclofenac sodium topical solution 2%	☐ Apply 40 mg (2 pump actuations) on each painful knee, 2 times a day ☐ Other: ______	4-week Supply	
☐ Prolia®	☐ 60 mg/1 mL in a PFS	☐ Administer 60 mg SC every 6 months (injection should be administered by a health-care provider)	4-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	4-week Supply	
☐ Rinvoq®	☐ 15 mg tablets	☐ Take 1 tablet by mouth daily	4-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	4-week Supply	
☐ Simponi®	☐ 50 mg PFS ☐ 50 mg SmartJect® ☐ 100 mg SmartJect® ☐ 100 mg PFS	☐ Inject 50 mg SC every 4 weeks ☐ Other: ______	3 1	0 ______
☐ 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	4-week Supply	
☐ Taltz®	☐ 80 mg/mL Autoinjector ☐ 80 mg/mL PFS	☐ **Starter Dose:** Inject 160 mg SC at week 0; then 80mg SC at weeks 2,4,6,8,10, & 12 ☐ **Maintenance Dose:** 80mg SQ every 4 weeks	4-week Supply	
☐ Tymlos®	☐ Prefilled Pen: (2000 mcg/mL) 30 daily doses of 80 mcg	☐ Inject 80 mcg SC as directed, once daily ☐ Pen needles for injection	4-week Supply	
☐ Xeljanz®	☐ 5 mg tablets ☐ 11mg XR tablets	☐ Take 1 tablet by mouth TWICE daily ☐ Take 1 tablet by mouth daily	4-week Supply	
☐ Vimovo®	☐ 375 mg naproxen /20 mg esomeprazole magnesium) ☐ 500 mg naproxen /20 mg esomeprazole magnesium)	☐ Take ______ tablets by mouth ______ daily	4-week Supply	
☐ Other:				

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

Prescriber Signature: Prescriber, please sign and date below	
	Date

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