

RA & INFLAMMATION (A-M) REFERRAL FORM

Updated July 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** **Multiuze 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
 HUMIRA 40 mg/0.8mL PFS Pens **HUMIRA CITRATE-FREE 40 mg/0.4mL** | PFS Pens
 SIG: Inject 40 mg subcutaneously every other week Patient weight (kg) _____ 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 (N-Z) REFERRAL FORM

Updated July 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

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PRESCRIPTION

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 QTY: 28 day supply Refill: _____
 250 mg Vial (IV use only)
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: _____

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 Prefilled Syringe 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: _____

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