ePrescribe to our pharmacy "Quality Specialty Pharmacy" located at 33617 in Tampa. Florida

Rheumatology Referral Form

PHONE: 800-961-6036 FAX: 877-266-4941

QUALITY SPECIALTY PHARMACY

Prescriber's Name: _____

DEA #: _____ NPI: _____

Address: _____ City, State, Zip: _____

Phone: _____ Fax: _____

Office Contact: _____

Date:_____ Needs by Date: _____

Language: _____ ☐ Nursing Instruction Required

Ship to: ☐ Patient ☐ MD Office ☐ Other:

PATIENT INFORMATION: Please complete the following or send patient demographic sheet.

Patient Name: _____ Date of Birth: ____/____/____ Weight: _____ lbs Gender: ☐ M ☐ F

Address: _____ City, State, Zip: _____

Home Phone: _____ Alternate: _____ Email: _____

PLEASE ATTACH ALL PRIMARY AND SECONDARY INSURANCE INFORMATION

CLINICAL INFORMATION: Please send recent clinical notes, current medications, labs, and tests to expedite the **Prior Authorization**.

Diagnosis: ☐ M32.10 SLE ☐ M06.9 RA ☐ M81.0 Osteoporosis ☐ M45.9 Ankylosing Spondylitis ☐ L40.59 Psoriatic Arthritis ☐ M19.90 Osteoarthritis ☐ Other:

☐ Treatment-naive Prior Failed Medications: _____ Duration and Reason for D/C: _____

Does the patient have a latex allergy? ☐ Yes ☐ No TB/PPD Test given? ☐ Yes ☐ No

Is the patient also taking methotrexate? ☐ Yes ☐ No Comments: _____

PRESCRIPTION INFORMATION

Medication	Strength	Directions/SIG	Quantity	Refill
☐ **Humira**	☐ 40 mg/0.8 mL PEN ☐ 40 mg/0.8 mL Syringe ☐ 20 mg/0.4 mL Syringe	☐ Inject 40 mg SC every OTHER week ☐ Inject 40 mg SC ONCE a week ☐ Other:		
☐ **Enbrel**	☐ 50 mg/mL Sureclick Autoinjector ☐ 50 mg/mL Prefilled Syringe	☐ Inject 50 mg SC ONCE a week	4	
		☐ Inject 50 mg SC TWICE a week	8	
☐ **Actemra**	☐ 162 mg/0.9 mL Syringe	☐ Inject 162 mg (0.9 mL) SC every week or ☐ Inject 162 mg (0.9 mL) SC every 2 weeks		
☐ **Benlysta**	☐ 120 mg Vial # _____ ☐ 400 mg Vial # _____	**Induction Dose**: ☐ Infuse _____ mg (10 mg/kg) IV every 2 weeks for the first 3 doses		
	☐ 120 mg Vial # _____ ☐ 400 mg Vial # _____	**Maintenance Dose**: ☐ Infuse _____ mg (10 mg/kg) IV every 4 weeks		
☐ **Cimzia**	☐ 200 mg/1 mL starter kit	**Induction Dose**: ☐ Inject 400 mg SC at week 0, at week 2, and at week 4	1 kit	X
	☐ 200 mg/1 mL PFS kit	**Maintenance Dose**: ☐ Inject 200 mg SC every OTHER week **or** ☐ Inject 400 mg SC every 4 weeks		
☐ **Forteo**	☐ 600 mcg/2.4 mL Pen	☐ Inject 20 mcg (0.08mL) SC as directed ONCE daily	2.4 mL	
☐ **B-D Ultra-Fine Mini**	☐ 5mm x 31 g PEN NEEDLES	Use daily with Forteo		
☐ **Orencia**	☐ 125 mg Prefilled Syringe ☐ 125 mg ClickJect Autoinjector	☐ Inject 125 mg SC Weekly ☐ Other: _____		
☐ **Prolia**	☐ 60 mg PFS	☐ Inject 60 mg SC every 6 months	1	
☐ **Remicade**	☐ 100 mg Vial	**Induction Dose:** Infuse 5 mg/kg at week 0, week 2, week 6, and every 8 weeks thereafter (**NO REFILLS**)	3 Vials	0
		Maintenance Dose: Infuse 5 mg/kg every 8 weeks **Other**: _____		
☐ **Simponi**	☐ 50 mg/0.5 mL SmartJect PEN ☐ 50 mg/0.5 mL Prefilled Syringe	☐ Infuse 50 mg SC once monthly		
☐ **Stelara**	☐ 45 mg/0.5 mL Prefilled Syringe	**Induction Dose**: ☐ Inject 45 mg SC at week 0 and 4, then every 12 weeks	0.5 mL	X
		Maintenance Dose: ☐ Inject 45 mg SC every 12 weeks	0.5 mL	
	☐ 90 mg/mL Prefilled Syringe	**Induction Dose**: ☐ Inject 90 mg SC at week 0 and 4, then every 12 weeks	1 mL	X
		Maintenance Dose: ☐ Inject 90 mg SC every 12 weeks	1 mL	
☐ **Xeljanz**	☐ 5 mg Tabs	☐ 1 tab twice daily	60	
☐ **Xeljanz XR**	☐ 11 mg Tabs	☐ 1 tab daily	30	
☐ **Other**				

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Physician Signature: _____ **Date:** _____