

# Rheumatology Referral Form



Prescriber's Name: \_\_\_\_\_

DEA #: \_\_\_\_\_ NPI: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Date: \_\_\_\_\_ Needs by Date: \_\_\_\_\_

Language: \_\_\_\_\_  Nursing Instruction Required

Office Contact: \_\_\_\_\_

Ship to:  Patient  MD Office  Other:

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

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Height \_\_\_\_\_ 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-naïve 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
<input type="checkbox"/> Humira	<input type="checkbox"/> 40 mg/0.8 mL PEN <input type="checkbox"/> 40 mg/0.8 mL Syringe <input type="checkbox"/> 20 mg/0.4 mL Syringe	<input type="checkbox"/> Inject 40 mg SC every OTHER week <input type="checkbox"/> Inject 40 mg SC ONCE a week <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Enbrel	<input type="checkbox"/> 50 mg/mL Sureclick Autoinjector <input type="checkbox"/> 50 mg/mL Prefilled Syringe	<input type="checkbox"/> Inject 50 mg SC ONCE a week <input type="checkbox"/> Inject 50 mg SC TWICE a week	4 8	
<input type="checkbox"/> Actemra	<input type="checkbox"/> 162 mg/0.9 mL Syringe	<input type="checkbox"/> Inject 162 mg (0.9 mL) SC every week or <input type="checkbox"/> Inject 162 mg (0.9 mL) SC every 2 weeks		
<input type="checkbox"/> Benlysta	<input type="checkbox"/> 120 mg Vial # _____ <input type="checkbox"/> 400 mg Vial # _____  <input type="checkbox"/> 120 mg Vial # _____ <input type="checkbox"/> 400 mg Vial # _____	<b>Induction Dose:</b> <input type="checkbox"/> Infuse _____ mg (10 mg/kg) IV every 2 weeks for the first 3 doses  <b>Maintenance Dose:</b> <input type="checkbox"/> Infuse _____ mg (10 mg/kg) IV every 4 weeks		X
<input type="checkbox"/> Cimzia	<input type="checkbox"/> 200 mg/1 mL starter kit  <input type="checkbox"/> 200 mg/1 mL PFS kit	<b>Induction Dose:</b> <input type="checkbox"/> Inject 400 mg SC at week 0, at week 2, and at week 4  <b>Maintenance Dose:</b> <input type="checkbox"/> Inject 200 mg SC every OTHER week or <input type="checkbox"/> Inject 400 mg SC every 4 weeks	1 kits	X
<input type="checkbox"/> Forteo	<input type="checkbox"/> 600 mcg/2.4 mL Pen	<input type="checkbox"/> Inject 20 mcg (0.08mL) SC as directed ONCE daily	2.4 mL	
<input type="checkbox"/> B-D # Gauge	<input type="checkbox"/> 5mm PEN NEEDLES	Use daily with Forteo		
<input type="checkbox"/> Orencia	<input type="checkbox"/> 125 mg Prefilled Syringe <input type="checkbox"/> 125 mg ClickJect Autoinjector	<input type="checkbox"/> Inject 125 mg SC Weekly <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Prolia	<input type="checkbox"/> 60 mg PFS	<input type="checkbox"/> Inject 60 mg SC every 6 months	1	
<input type="checkbox"/> Remicade	<input type="checkbox"/> 100 mg Vial	<b>Induction Dose:</b> Infuse 5 mg/kg at week 0, week 2, week 6, and every 8 weeks thereafter <b>(NO REFILLS)</b>  <b>Maintenance Dose:</b> Infuse 5 mg/kg every 8 weeks <b>Other:</b> _____	3 Vials	X
<input type="checkbox"/> Simponi	<input type="checkbox"/> 50 mg/0.5 mL SmartJect PEN <input type="checkbox"/> 50 mg/0.5 mL Prefilled Syringe	<input type="checkbox"/> Infuse 50 mg SC once monthly		
<input type="checkbox"/> Stelara	<input type="checkbox"/> 45 mg/0.5 mL Prefilled Syringe  <input type="checkbox"/> 90 mg/mL Prefilled Syringe	<b>Induction Dose:</b> <input type="checkbox"/> Inject 45 mg SC at week 0 and 4, then every 12 weeks <b>Maintenance Dose:</b> <input type="checkbox"/> Inject 45 mg SC every 12 weeks  <b>Induction Dose:</b> <input type="checkbox"/> Inject 90 mg SC at week 0 and 4, then every 12 weeks <b>Maintenance Dose:</b> <input type="checkbox"/> Inject 90 mg SC every 12 weeks	0.5 mL 0.5 mL 1 mL 1 mL	X  X
<input type="checkbox"/> Xeljanz	<input type="checkbox"/> 5 mg Tabs	<input type="checkbox"/> 1 tab twice daily	60	
<input type="checkbox"/> Xeljanz XR	<input type="checkbox"/> 11 mg Tabs	<input type="checkbox"/> 1 tab daily	30	
<input type="checkbox"/> Other				

**QUALITY SPECIALTY PHARMACY**

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_  Dispense as written Initial \_\_\_\_\_

**\*Prescription is VOID if the Number of drugs prescribed is NOT noted.** \_\_\_\_\_  1  2  3

**IMPORTANT NOTICE:** This facsimile is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the center at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitter material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee.