# Rheumatology Referral Form

**Date:** _____

## Evolutionary Pharmacy Solutions

**Fax Referral To: 1-800-239-0363**
**Phone: 1-844-800-5377**

EPSRX

| PATIENT INFORMATION: | PRESCRIBER INFORMATION: |
|---|---|
| Patient Name: _____ | Prescriber Name: _____ |
| Address: _____ | Address: _____ |
| City, State, Zip: _____ | City, State, Zip: _____ |
| Cell Phone: _____ | Phone: _____ |
| Home Phone: _____ Language: _____ | Fax: _____ |
| Date of Birth: _____ Gender: ☐ Male ☐ Female | DEA: _____ NPI: _____ |
| Guardian/Caregiver & Number: _____ | Office Contact: _____ |

## INSURANCE INFORMATION

Attach a copy of the Front and Back of the Insurance and Prescription Card. Prior Authorization Reference Number: _____

## CLINICAL INFORMATION

**DIAGNOSIS: ICD-10 code**
- ☐ M06.9 Rheumatoid Arthritis
- ☐ M08.0 Juvenile Rheumatoid Arthritis
- ☐ M45.9 Ankylosing Spondylitis
- ☐ L40.59 Psoriatic Arthritis
- ☐ Other Diagnosis: _____

Date of Diagnosis: _____
**Other Conditions:** _____

**Ship to:** ☐ Patient ☐ Office ☐ First Fill to Office Date Needed: _____ Weight(kg): _____
CrCl: _____ **Hep B** rule out: ☐ Yes ☐ No **TB test** performed: ☐ Yes ☐ No Results: _____
**Therapy** ☐ New ☐ Reauthorization ☐ Restart **Prior Therapy:** _____
Tx Response & Dates: _____
**Injection Training**: ☐ Patient trained ☐ Physician's office to train ☐ Pharmacy to coordinate training
Concomitant Medications: _____
Allergies: _____

| | Dose/Strength | Directions | Quantity | Refills |
|---|---|---|---|---|
| ☐ **Actemra** | ☐ 80mg/4ml vial ☐ 200mg/10ml vial<br>☐ 400mg/10ml vial ☐ 162mg/0.9ml PFS | ☐ Infuse _____ (mg/kg) IV every 4 weeks<br>☐ Infuse 162mg SQ every week ☐ Infuse 162mg SQ every other week | | |
| ☐ **Benlysta** | ☐ 200mg/ml Autoinjector ☐ 120mg vial<br>☐ 200mg/ml PFS ☐ 400 mg vial | ☐ Inject 200mg SQ once weekly in abdomen or thigh | | |
| ☐ **Cimzia** | ☐ 200mg Starter kit ☐ 200 mg/ml vial<br>☐ 200 mg/ml PFS | ☐ Initial Dose: Inject 400 SQ at weeks 0,2 and 4<br>☐ Inject 400 SQ every 2 weeks ☐ Inject 200 SQ every 4 weeks | | |
| ☐ **Cosentyx** | ☐ 150 mg/ml Pen ☐ 150mg/ml Pen (2 Pack)<br>☐ 150mg/ml PFS ☐ 150mg/ml PFS (2 Pack) | ☐ Initial: Inject 150mg **OR** ☐ Inject 300mg SQ at weeks 0,1,2,3 and 4<br>☐ Maintenance: Inject 150mg **OR** ☐ Inject 300mg SQ every 4 weeks | | |
| ☐ **Enbrel** | ☐ 25mg/0.5ml PFS ☐ 25mg/0.5ml via<br>☐ 50mg/ml PFS l ☐ 50mg/ml Sureclick | ☐ Inject 25mg SQ twice a week (72-96 hours apart)<br>☐ Inject 50mg SQ once a week | | |
| ☐ **Humira** | ☐ 20mg/0.4ml PFS<br>☐ 40mg/0.8ml PFS ☐ 40mg/0.8ml pen | ☐ Inject 20mg SQ every 2 weeks<br>☐ Inject 40mg SQ every 2 weeks ☐ Inject 40mg SQ every week | | |
| ☐ **Kevzara** | ☐ 150mg/1.14ml PFS<br>☐ 200mg/1.14ml PFS | ☐ Inject 150mg SQ every 2 weeks<br>☐ Inject 200mg SQ every 2 weeks | | |
| ☐ **Olumiant** | ☐ 2mg tablet | ☐ Take 2mg PO every day as monotherapy or in combination | | |
| ☐ **Orencia** | ☐ 125mg/ml Pen ☐ 250mg vial<br>☐ 125mg/ml PFS ☐ Other _____ | ☐ Inject 200mg SQ every 2 weeks ☐ Inject 125mg SQ once a week<br>☐ Other _____ | | |
| ☐ **Otezla** | ☐ Starter Pack (10/20/30mg)<br>☐ 30mg tablets | ☐ Titration Pack: Use as directed ☐ Bridge Pack: Use as directed<br>☐ Maintenance: Take 30mg by mouth twice daily | | |
| ☐ **Remicade**<br>☐ **Inflectra**<br>☐ **Renflexis** | ☐ 100mg vial | ☐ Initial Dose: Infuse _____ mg/kg IV at week 0, week 2, week 6<br>then ☐ Maintenance Dose: Infuse _____mg/kg once every 8 weeks<br>☐ Other _____ | | |
| ☐ **Rituxan** | ☐ 100mg/10ml vial ☐ 500mg/50ml vial | | | |
| ☐ **Simponi**<br>☐ **Simponi Aria** | ☐ 50mg/0.5ml AI ☐ 100mg/0.5ml PFS<br>☐ 50mg/0.5ml PFS ☐ 50mg/4ml vial | ☐ Inject 50mg SQ once a month<br>☐ Infuse 2mg/kg IV over 30 min at weeks 0 & 4, then every 8 weeks | | |
| ☐ **Stelara** | ☐ 45mg/0.5mg PFS ☐ 45mg/0.5mg vial<br>☐ 90mg/1mg PFS | ☐ Initial: Inject 45mg SQ on day 1 ☐ OR Inject 90mg SQ on day 1<br>☐ Inject 45mg SQ every 12 weeks ☐ OR Inject 90mg every 12 weeks☐<br>Maintenance: Inject 90mg SQ on day 29 & every 12 weeks after | | |
| ☐ **Taltz** | ☐ 80mg/ml Autoinjector ☐ 80mg/ml PFS | ☐ Inject 160mg SQ once then 80mg every 4 weeks<br>☐ Inject 160mg SQ once then 80mg at weeks 2,4,6,8,10,12 then Q4 weeks | | |
| ☐ **Xeljanz** | ☐ 5mg tablet | ☐ Take 1 tablet PO every day ☐ Take 1 tablet PO twice daily | | |
| ☐ **Xeljanz XR** | ☐ 11mg XR tablet | ☐ Take 1 tablet PO every day | | |

**Patient Support Programs**: To enroll in manufacturer assisted patient support program: **Patient Signature:** _____ **Date:** _____

**PRESCRIBER SIGNATURE:** _____ **DATE:** _____
Verbal Readback ☐ Yes ☐ No ***Stamp signature not allowed, physician signature required *** ☐ Product substitution permitted ☐ Dispense as written