Date:_____

Rheumatology Referral Form

PATIENT INFORMATION:

Patient Name: _____
Address: _____
City, State, Zip: _____
Cell Phone: _____
Home Phone: _____Language:_____
Date of Birth: _____ Gender: ☐ Male ☐ Female
Guardian/Caregiver & Number: _____

PRESCRIBER INFORMATION:

Prescriber Name: _____
Address: _____
City, State, Zip: _____
Phone: _____
Fax: _____
DEA:_____ NPI: _____
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 ☐ 400mg/10ml vial ☐ 162mg/0.9ml PFS	☐ Infuse _____ (mg/kg) IV every 4 weeks ☐ Infuse 162mg SQ every week ☐ Infuse 162mg SQ every other week		
☐ **Benlysta**	☐ 200mg/ml Autoinjector ☐ 120mg vial ☐ 200mg/ml PFS ☐ 400 mg vial	☐ Inject 200mg SQ once weekly in abdomen or thigh		
☐ **Cimzia**	☐ 200mg Starter kit ☐ 200 mg/ml vial ☐ 200 mg/ml PFS	☐ Initial Dose: Inject 400 SQ at weeks 0,2 and 4 ☐ Inject 400 mg SQ every 2 weeks ☐ Inject 200 mg SQ every 4 weeks		
☐ **Cosentyx**	☐ 150 mg/ml Pen ☐ 150mg/ml Pen (2 Pack) ☐ 150mg/ml PFS ☐ 150mg/ml PFS (2 Pack)	☐ Initial: Inject 150mg **OR** ☐ Inject 300mg SQ at weeks 0,1,2,3 and 4 ☐ Maintenance: Inject 150mg **OR** ☐ Inject 300mg SQ every 4 weeks		
☐ **Enbrel**	☐ 25mg/0.5ml PFS ☐ 25mg/0.5ml via ☐ 50mg/ml PFS l ☐ 50mg/ml Sureclick	☐ Inject 25mg SQ twice a week (72-96 hours apart) ☐ Inject 50mg SQ once a week		
☐ **Humira**	☐ 20mg/0.4ml PFS ☐ 40mg/0.8ml PFS ☐ 40mg/0.8ml pen	☐ Inject 20mg SQ every 2 weeks ☐ Inject 40mg SQ every 2 weeks ☐ Inject 40mg SQ every week		
☐ **Kevzara**	☐ 150mg/1.14ml PFS ☐ 200mg/1.14ml PFS	☐ Inject 150mg SQ every 2 weeks ☐ 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 ☐ 125mg/ml PFS ☐ Other _____	☐ Inject 200mg SQ every 2 weeks ☐ Inject 125mg SQ once a week ☐ Other _____		
☐ **Otezla**	☐ Starter Pack (10/20/30mg) ☐ 30mg tablets	☐ Titration Pack: Use as directed ☐ Bridge Pack: Use as directed ☐ Maintenance: Take 30mg by mouth twice daily		
☐ **Remicade** ☐ **Inflectra** ☐ **Renflexis**	☐ 100mg vial	☐ Initial Dose: Infuse _____ mg/kg IV at week 0, week 2, week 6 then ☐ Maintenance Dose: Infuse _____mg/kg once every 8 weeks ☐ Other _____		
☐ **Rituxan**	☐ 100mg/10ml vial ☐ 500mg/50ml vial			
☐ **Simponi** ☐ **Simponi Aria**	☐ 50mg/0.5ml AI ☐ 100mg/0.5ml PFS ☐ 50mg/0.5ml PFS ☐ 50mg/4ml vial	☐ Inject 50mg SQ once a month ☐ Infuse 2mg/kg IV over 30 min at weeks 0 & 4, then every 8 weeks		
☐ **Stelara**	☐ 45mg/0.5mg PFS ☐ 45mg/0.5mg vial ☐ 90mg/1mg PFS	☐ Initial: Inject 45mg SQ on day 1 ☐ OR Inject 90mg SQ on day 1 ☐ Inject 45mg SQ every 12 weeks ☐ OR Inject 90mg every 12 weeks☐ 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 ☐ 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