PARK AVENUE PHARMACY

SPECIALTY CARE SOLUTIONS

Rheumatology R_x Referral Form

3712 Park Ave. Weehawken, NJ 07086
Phone: (201)552-9500 Fax:(888)332-4494
Info@parkaverx.com www.parkaverx.com
E-Scripts NCPDP#3199367 NPI#1881932093

Date Medication Needed: _____ Ship To: ☐ Patient's Home ☐ Prescriber's Office ☐ Or Pick-up from Pharmacy

Injection needed by pharmacy? ☐ Yes ☐ No

1: Patient Information

Patient Name: _____ Birthdate: _____ Sex: Male Female Height: _____ Weight: _____ lbs. kg.

Soc. Sec. #: _____ Preferred Phone: _____ Known Allergies: _____

Address: _____ City: _____ State: _____ Zip: _____

Alternate Caregiver Name: _____ Preferred Phone: _____

Insurance Information: Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)

2: Diagnosis/Clinical Information | *Please FAX recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization*

ICD-10: Diagnosis Code: ☐ M06.9 (Rheumatoid Arthritis) ☐ M08.0 (Juvenile Idiopathic Arthritis) ☐ L40.59 (Psoriatic Arthritis)
☐ L40.54 (Psoriatic Juvenille Arthritis) ☐ M45.9 (Ankylosing Spondylitis) ☐ _____

Previously treated for this condition ☐ Yes ☐ No Medication(s) failed _____

Patient currently taking Methotrexate ☐ Yes ☐ No For Humira/ Enbrel: PPD (TB Test) ☐ Yes ☐ No

Does patient have latex allergy (For Enbrel) ☐ Yes ☐ No Total Swollen Joints_____ Rehumatoid factor positive_____

Osteoporotic Fracture History: Site_____ Date_____ For Forteo: T-Score_____ Date_____

3: Prescriber Information

Prescriber Name: _____ DEA#: _____ NPI#: _____ Tax ID#: _____

Address: _____ Phone: (_____) _____ - _____ Fax: (_____) _____ - _____

City: _____ State: _____ Zip: _____ Key Contact: _____ Phone: (_____) _____ - _____

4: Prescription Information

§ Actemra®, Cimzia®, Cosentyx®, Enbrel® are available on the Rheumatology Enrollment Form A-E §

Medication	Directions	Quantity		Refill
☐ **Humira® (adalimumab)** *Adults & Pediatrics Age ≥ 2 years*	☐ Inject 10 mg subcut every other week (10 to <15 kg) ☐ Inject 20 mg subcut every other week (15 to <30 kg)	☐ 2 x 10 mg/0.2mL ☐ 2 x 20 mg/0.4mL	PFS	
	☐ Inject 40 mg subcut every other week (≥30 kg) ☐ Inject 40 mg subcut once weekly	☐ 2 x 40 mg/0.8mL ☐ 4 x 40 mg/0.8mL	☐ Pens ☐ PFS	_____
☐ **Kevzara® (sarilumab)**	☐ Inject 150 mg subcut every other week ☐ Inject 200 mg subcut every other week	☐ 2 x 150 mg/1.14mL ☐ 2 x 200 mg/1.14mL	PFS	_____
☐ **Orencia® (abatacept)**	☐ Infuse _____ mg at week 0 **only** ☐ Infuse _____ mg at weeks 0 and 2	☐ ____ x 250 mg	Vials	0
	(JIA <75 kg: 10 mg/kg; JIA ≥75 kg or RA:<60 kg: 500 mg, 60-100 kg: 750 mg; >100 kg: 1000 mg)			
	☐ Infuse _____ mg at week 4 and every 4 weeks thereafter	☐ ____ x 250 mg	Vials	_____
	(JIA <75 kg: 10 mg/kg; JIA ≥75 kg or RA:<60 kg: 500 mg, 60-100 kg: 750 mg; >100 kg: 1000 mg)			
	☐ Inject 125 mg subcut once weekly	☐ 4 x 125 mg/mL	☐ PFS ☐ ClickJect™	_____
☐ **Otezla® (apremilast)**	☐ Take as directed per package instruction	☐ 55 Tablets	28-day starter pack	0
	☐ Take 30 mg by mouth twice daily ☐ _____	☐ 60 x 30 mg tablets ☐ _____		_____

§ Simponia®, Simponi Aria®, Stelara®, Xeljanz®, Xeljanz® XR are available on the Rheumatology Enrollment Form S-Z §

Patient Support Programs: Please sign and date below to enroll in the pharmaceutical company assisted patient support program

Patient Signature: _____ Date: _____

I authorize Park Ave. Pharmacy and its representatives to act as an agent to execute Prior authorization process.

Prescriber Signature: Prescriber, please sign and date below

Substitution Permissable _____ Date _____ Dispense as written _____ Date _____