



# Rheumatology Rx Referral Form

SPECIALTY CARE SOLUTIONS

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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 Juvenile 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 \_\_\_\_\_ Rheumatoid 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 §  
 § Humira®, Kevzara®, Orencia®, Otezla® XR are available on the Rheumatology Enrollment Form F-R §

Medication	Directions	Quantity		Refill
<input type="checkbox"/> <b>Simponi® (golimumab)</b>	<input type="checkbox"/> Inject 50 mg subcut once a month	<input type="checkbox"/> 1 x 50 mg/0.5mL	<input type="checkbox"/> Smartject® Autoinjector <input type="checkbox"/> PFS	_____
<input type="checkbox"/> <b>Simponi Aria® (golimumab)</b>	<input type="checkbox"/> Infuse _____ mg (2 mg/kg x _____ kg) over 30 minutes at weeks 0	<input type="checkbox"/> _____ x 50 mg/4ml	Vials	0
	<input type="checkbox"/> Infuse _____ mg (2 mg/kg x _____ kg) over 30 minutes at week 4 and every 8 weeks thereafter	<input type="checkbox"/> _____ x 50 mg/4ml	Vials	_____
<input type="checkbox"/> <b>Stelara® (ustekinumab)</b>	<input type="checkbox"/> Inject 45 mg subcut on Day 1 (≤100 kg)	<input type="checkbox"/> 1 x 45mg/0.5mL	PFS	0
	<input type="checkbox"/> Inject 90 mg subcut on Day 1 (>100 kg)	<input type="checkbox"/> 1 x 90mg/mL		
	<input type="checkbox"/> Inject 45 mg subcut on Day 29 and every 12 weeks thereafter (≤100 kg)	<input type="checkbox"/> 1 x 45mg/0.5mL	PFS	_____
<input type="checkbox"/> <b>Xeljanz® (tofacitinib)</b>	<input type="checkbox"/> Take 5 mg by mouth twice daily	<input type="checkbox"/> 60 x 5 mg tablets		_____
	<input type="checkbox"/> _____	<input type="checkbox"/> _____		_____
<input type="checkbox"/> <b>Xeljanz® XR (tofacitinib)</b>	<input type="checkbox"/> Take 5 mg by mouth twice daily	<input type="checkbox"/> 30 x 11 mg tablets		_____

**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 Permissible \_\_\_\_\_ Date \_\_\_\_\_ Dispense as written \_\_\_\_\_ Date \_\_\_\_\_

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.