SPECIALTY CARE SOLUTIONS

Rheumatology Rx Referral Form

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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 (Juvenille 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

Medication	Directions	Quantity		Refill
☐ **Actemra®** **(tocilizumab)**	☐ Inject 162 mg subcut every week ☐ Inject 162 mg subcut every other week ☐ ____________	☐ 4 x 162 mg/0.9mL ☐ 2 x 162 mg/0.9mL ☐ ________	☐ PFS ☐ Vials	______
☐ **Cimzia®** **(certolizumab)**	☐ Inject 400 mg subcut at weeks 0, 2 and 4	☐ 6 x 200 mg/mL	☐ PFS ☐ Vials	0
	☐ Inject 200 mg subcut every 2 weeks ☐ Inject 400 mg subcut every 4 weeks	☐ 2 x 200 mg/mL	☐ PFS ☐ Vials	______
☐ **Cosentyx®** **(secukinumab)**	☐ Inject 150 mg subcut once weekly at weeks 0, 1, 2 and 3 ☐ Inject 300 mg subcut once weekly at weeks 0, 1, 2 and 3	☐ 4 x 150 mg/mL ☐ 8 x 150 mg/mL	☐ Sensoready® Pen ☐ PFS	0
	☐ Inject 150 mg subcut on week 4 and every 4 weeks thereafter ☐ Inject 300 mg subcut on week 4 and every 4 weeks thereafter	☐ 1 x 150 mg/mL ☐ 2 x 150 mg/mL	☐ Sensoready® Pen ☐ PFS	______
☐ **Enbrel®** **(etanercept)**	☐ Inject 50 mg subcut every week ☐ Inject _____ mg (0.8 mg/kg x _____ kg) subcut every week	☐ 4 x 50 mg/mL ☐ ____ x 25 mg/mL	☐ SureClick® Autoinjector ☐ Mini™ Cartridge ☐ PFS ☐ Vials	______

§ Humira®, Kevzara®, Orencia®, Otezla® are available on the Rheumatology Enrollment Form F-R §
§ 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 ______

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.