RHEUMATOLOGY REFERRAL FORM

Jersey Shore Pharmacy

580 N. Main Street • Barnegat, NJ 08005
Phone: 609-660-1111 • Fax: 609-660-0101

Today's Date

☐ CURRENT PATIENT
☐ NEW PATIENT

Patient Name _____ Date of Birth _____
☐ Male ☐ Female SS# _____ Language _____
Address _____ Apt # _____
City _____ State _____ ZIP _____
Phone _____ Cell _____ Email _____
Allergies _____
Ship to Patient at ☐ Home ☐ Work
OR Patient will pick up at ☐ Jersey Shore Pharmacy ☐ Physician Office

Insured's Name _____
Relation to Patient _____
Eligible for Medicare? ☐ Yes ☐ No If yes, Medicare# _____
Prescription Card ☐ Yes ☐ No If Yes, Carrier _____
Phone _____ Fax _____
Policy/Group# _____
Bin# _____ Pcn# _____
RXID# _____ RX Group# _____

ICD-10: ☐ L40.59 Psoriatic Arthritis ☐ M32.10 SLE ☐ M06.9 Rheumatoid Arthritis ☐ M45.9 Ankylosing Spondylitis ☐ Other _____
Previously treated for this condition? ☐ Yes ☐ No Medication(s) failed _____
Patient currently taking Methotrexate? ☐ Yes ☐ No For Humira/Enbrel: PPD (TB Test) Results _____ Date _____
Rheumatoid Factor Positive _____ Total Swollen Joints _____ Latex Allergy? ☐ Yes ☐ No

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

TALTZ 80mg ☐ Autoinjector ☐ Prefilled Syringe
Psoriatic Arthritis Start Dose: ☐ 160 mg SQ at wk 0, followed by 80 mg every 4 wks QTY: 2 Refill: _____
Maintenance: ☐ Inject 80mg SQ every 4 weeks QTY: _____ Refill: _____
☐ Other: _____ QTY: _____ Refill: _____

KEVZARA® (sarilumab) ☐ 200 mg/1.14 mL PFS ☐ 150 mg/1.14 mL PFS
Dispense: ☐ Inject 150 mg subcutaneously every other week QTY: 2 Refill: _____
☐ Inject 200 mg subcutaneously every other week QTY: 2 Refill: _____

ACTEMRA® Prefilled-Syringe QTY: _____ Refill: _____
☐ Inject 162mg subcutaneously every other week (pt wt<100kg)
☐ Inject 162mg subcutaneously every week (pt wt >100kg or per clinical response)

CIMZIA® QTY: _____ Refill: _____
Starting Dose: ☐ 400mg (two 200mg SQ injections) at weeks 0, 2 & 4 (Starter Kit #6)
Maintenance Dose: ☐ 200mg SQ injection every other week
☐ Other _____

HUMIRA® **Dose:** ☐ 40mg/0.8mL PFS ☐ 40mg/0.8mL Pens ☐ 20mg/0.4mL PFS
Patient weight (kg) _____ **Dispense:** ☐ Inject 40mg SQ every other week QTY: _____ Refill: _____

OTEZLA® ☐ Titration Starter Pack SIG: Take as directed QTY: 55 for 28 days
☐ Maintenance: 30 mg SIG: Take 30mg twice a day QTY: 60 Refill: _____

ORENCIA® ☐ 125mg PFS ☐ 250mg Vial ☐ 125mg ClickJect™ Auto Injector
☐ Inject 125mg SC weekly ☐ Other _____
QTY: ☐ 4 week supply ☐ Other _____ Refill: _____

SIMPONI® **Dose:** *SmartJect*™ ☐ 50mg/0.5mL | Prefilled Syringe ☐ 50mg/0.5mL
SIG: ☐ Inject 50mg SQ once per month
KINERET® SIG: ☐ Inject _____ mg SQ every day QTY: _____ Refill: _____

STELARA **Starting Dose:** ☐ 45 mg ☐ 90mg SQ initially & 4 weeks later
Maintenance Dose: ☐ 45 mg ☐ 90mg SQ every 12 weeks QTY: _____ Refill: _____

ENBREL® **Dose:** PFS ☐ 25mg ☐ 50mg *SureClick*™ ☐ 50mg | Multiuse Vial ☐ 25mg
Dispense: ☐ 1 x week ☐ 2 x week QTY: _____ Refill: _____

XELJANZ® ☐ 5 mg tablet **XELJANZ XR®** ☐ 11 mg tablet
Rheumatoid Arthritis ☐ 5 mg twice daily **OR** ☐ 11 mg once daily
Psoriatic Arthritis ☐ 5 mg twice daily OR ☐ 11 mg once daily used in combination with nonbiologic DMARDs
Other _____ QTY: _____ Refill: _____

OTHER _____ Dosage: _____
SIG: _____ QTY: _____ Refill: _____

Prescriber's Name / Practice _____ Office Contact _____
Address _____ Suite# _____ City _____ State _____ ZIP _____
Phone _____ Fax _____ Email _____
License# _____ NPI# _____ UPIN# _____ DEA# _____

Prescriber's Signature (signature required. NO STAMPS) _____ **Date** _____

By signing this form and utilizing our services, you are authorizing Jersey Shore Pharmacy and it's employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.