RHEUMATOLOGY REFERRAL FORM

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
Patient currently taking Methotrexate? ☐ Yes ☐ No
Rheumatoid Factor Positive________
Medication(s) failed ________________
For Humira/Enbrel: PPD (TB Test) Results________________ Date________
Total Swollen Joints________ Latex Allergy? ☐ Yes ☐ No

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

OLUMIANT (baricitinib)
SIG: ☐ 2mg PO once daily with or without food QTY: 30 Refills: ______

TALTZ 80mg ☐ Autoinjector ☐ Prefilled Syringe
Psoriatic Arthritis Start Dose: ☐ 160 mg SQ at wk 0, followed by 80 mg every 4 weeks 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 w/ 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.

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