Rheumatology Referral Form

3592 W. MAPLE RD • BLOOMFIELD HILLS, MI 48301
248.644.6337 • Fax: 248.644.1027
WEB: www.thevillagerx.net • EMAIL: info@thevillagerx.net

Patient Information

☐ New Rx ☐ Refill

Name | Date of Birth | Home Phone Number | Other Phone Number

Address | City | State | Zip

Patient SS# | ☐ Allergies | ☐ No Known Allergies

Drug Delivery Info

Date Shipment Needed: **Ship to:** ☐ Patient ☐ Clinic

Insurance Info [Fax a copy of the patient's insurance card (both sides.)]

Doctor/Prescriber Info [NPI # is mandatory.]

Name: | Office Contact :

Address: | City: | State: | Zip:

NPI # | Phone # | Fax #

Statement of Medical Necessity ** Please FAX recent clinical notes, tests, with the prescription to expedite the Prior Authorization.

Patient Weight: | ICD9 Code: | ESR Date: | CRP Date:

Tendor Joints: | # Swollen Joints: | TB/PPD Test given Date:

Prior Medications Failed:

Medication	Dose/Strength	Directions	Qty	Rfs
Cimzia® (certolizumab pegol)	☐ 200mg/ml Starter Kit ☐ 200mg/ml Vial ☐ 200mg/ml Prefilled Syringes	☐ **Initial:** Inject 400mg SQ, repeat dose 2 and 4 weeks after initial dose ☐ **Maintenance:** Inject 200mg SQ every other week ☐ Inject 400mg every 4 weeks		
Enbrel® (etanercept)	☐ 25mg multi use vial ☐ 25mg/0.5ml Prefilled Syringe ☐ 50mg/ml Prefilled Syringe ☐ 50mg/ml SureClick Autoinjector	☐ Once Weekly: Inject 50mg SQ once weekly ☐ Twice Weekly: Inject 25mg SQ twice weekly (72 to 96 hours apart)		
Humira® (adalimumab)	☐ 40mg/0.8ml Prefilled Pen Kit ☐ 40mg/0.8ml Prefilled Syringe Kit	☐ Inject 40mg SQ every other week. ☐ Inject 40mg SQ every week (Not Taking Methotrexate)		
Humira Injection Training	☐ The myHUMIRA Nurse (RN) is to provide subcutaneous injection training for HUMIRA, including administration by the myHUMIRA Nurse (RN) as needed.			
Kineret® (anakinra)	☐ 100mg/0.67ml Prefilled syringe	☐ Inject 100mg SQ every day		
Orencia® (abatacept)	☐ 125mg/ml Prefilled Syringe	☐ Inject 125mg SQ once per week		
Simponi® (golimumab)	☐ 50mg/0.5ml SmartJect ☐ 50mg/0.5ml Prefilled Syringe	☐ Inject 50mg SQ once per month.		
Xeljanz® (tofacitinib)	☐ 5mg tablets	☐ 5mg PO BID ☐ 5mg PO QD		
Stelara® (ustekinumab)	☐ 45mg/0.5mL Prefilled syringe ☐ 90mg/ml Prefilled Syringe	☐ Initial: Inject 45mg initially and 4 weeks later followed by 45mg every 12 weeks ☐ Initial: Inject 90mg initially and 4 weeks later followed by 90 mg every 12 weeks ☐ Maintenance: Inject 45mg every 12 weeks ☐ Maintenance: Inject 90mg every 12 weeks		
Actemra (tocilzumab)	☐ 162mg/0.9ml Prefilled syringe	☐ Inject 1 syringe SQ every week ☐ Inject 1 syringe SQ every other week		
Otezla	☐ Starter Pack ☐ 30mg	☐ Day 1: 10 mg in morning ☐ Day 2: 10 mg in morning and 10 mg in evening ☐ Day 3: 10 mg in morning and 20 mg in evening ☐ Day 4: 20 mg in morning and 20 mg in evening ☐ Day 5: 20 mg in morning and 30 mg in evening ☐ Day 6 and thereafter: 30 mg twice daily ☐ 30mg sig: Take one tablet by mouth twice daily.		

Doctor/Prescriber Signature

Print Save

Federally approved, generic-equivalent medications will be dispensed for brand-name medications unless otherwise directed by the patient, physician, or health plan. IMPORTANT CONFIDENTIALITY NOTICE: This and any documents accompanying this transmission may contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity name above. He authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the content of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.