RHEUMATOLOGY REFERRAL FORM

Est. 1927
Silver Rod Specialty Care Pharmacy

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Fax: 888-910-0186
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Today's Date **Anticipated Start Date**

☐ **NEW PATIENT** ☐ **CURRENT PATIENT**

PATIENT INFORMATION:

Patient Name _____ DOB_____ Weight_____ ☐ Male ☐ Female
Street Address_____ Apt#_____ City_____ State_____ Zip_____
Daytime Tel_____ Even Tel_____ Cell_____ Email_____
Ship to Patient at ☐ Home ☐ Work **OR** Patient will pick up at ☐ Physician Office ☐ Pharmacy Date Needed_____

Insured's Name_____ Relation to Patient_____ Eligible for Medicare ☐ Yes ☐ No If yes, Medicare#_____
Prescription Card Yes No If Yes, Carrier_____ Tel_____ Fax_____ Policy/Group#_____
Bin#_____ Pcn#_____ RX Group#_____ RXID#_____

PRESCRIBING PHYSICIAN INFORMATION:

Prescriber's Name_____ Office Contact_____
Street Address_____ Suite#_____ City_____ State_____ Zip_____
Tel_____ Fax_____ Email_____
License#_____ NPI#_____ UPIN#_____ DEA#_____

CLINICAL INFORMATION:

Diagnosis/ICD-10:
☐ Rheumatoid Arthritis (M06.9)
☐ Ankylosing Spondylitis (M45.9)
☐ Psoriatic Arthritis (L40.5)
☐ Other:_____
☐ Date of diagnosis:_____

Other Clinical Information:
-Is patient taking methotrexate? ☐ Yes ☐ No
-TB/PPD test given? ☐ Yes ☐ No
Date of negative test: _____
-HBV Positive? ☐ Yes ☐ No
-If no, has treatment been initiated? ☐ Yes ☐ No

Current/Prior Therapies:
Please include medication name/strength, duration of rx, and reason for discontinuation
_____
_____
_____

PRESCRIPTION

PLEASE E-SCRIBE & ATTACH COPIES OF PATIENT'S INSURANCE CARDS

Medication	Dose/Strength	Directions	Quantity	Refills
☐ **ACTEMRA®**	162 mg/0.9 mL PFS	162 mg SQ every OTHER week 162 mg SQ ONCE a week	2 PFS 4 PFS	
☐ **CIMZIA®**	**Starter Dose:** Starter Kit (6 x 200 mg PFS) **Maintenance Dose:** 200 mg/mL PFS	400 mg SQ at weeks 0, 2, 4 400 mg SQ every 4 weeks	1 kit 4-week supply	
☐ **ENBREL®**	50 mg/mL SureClick® 50 mg/mL PFS	Inject 50 mg SQ ONCE a week Inject 25 mg SQ TWICE a week	4-week supply	
HUMIRA®	40 mg/0.8 mL PEN 40 mg/0.8 mL PFS	Inject 40 mg SQ every OTHER week Inject 40 mg SQ ONCE a week Other:_____	4-week supply	
ORENCIA®	250 mg vial (IV use) 125 mg/mL PFS 125 mg/mL Clickjet®	Loading dose: 10 mg/kg IV x 1 dose, then 125 mg SQ weekly, start within 24 hours of IV dose 125 mg SQ ONCE a week	1 dose 4-week supply	
OTEZLA®	Starter Pack 30 mg tablet	As directed 30 mg PO TWICE daily	55 tablets 60 tablets	
OTREXUP®	_____ mg/0.4 mL	Inject SQ ONCE a week	4-week supply	
RASUVO®	_____ mg/_____ mL	Inject SQ ONCE a week	4-week supply	
SIMPONI®	50 mg/0.5 mL Autoinjector 50 mg/0.5 mL PFS	Inject 50 mg SQ ONCE monthly 2 mg/kg IV infusion over 30 min at week 0	1 dose	
STELARA®	45 mg/0.5 mL PFS 90 mg/mL PFS	Inject contents of 1 PFS SQ on day 1 Inject contents of 1 PFS SQ starting day 29 & every 12 weeks thereafter	1 PFS	
XELJANZ®	5 mg tablet 11 mg XR	5 mg PO TWICE daily 11 mg QD	60 tablets 30 tablets	

PRESCRIBER SIGNATURE: (signature required. NO STAMPS) **DATE:**