MEDQUICK PHARMACY

Rheumatology Referral Form

Phone 877.421.3405 Fax 877.421.3406
546 West Las Tunas Drive, San Gabriel, CA 91776

Patient Information

Name (last, first)	Phone ❑Home ❑Cell	Date of Birth
Home Address, City, State		ZIP
Shipping Address, City, State (if different from above)		ZIP

Social Security Number	❑ Male ❑ Female	Allergies

Healthcare Provider Information

Prescriber's First and Last Name	Phone	Fax
Address, City, State		ZIP

Nurse/Key Contact	Physician NPI	DEA	License

Insurance Information *(attach copies of card and fax along with this form)*

Primary Insurance	Phone	Name (Insured ❑ Self, ❑ Spouse, ❑ Dependent)	ID Number	RXGRP
Secondary Insurance	Phone	Name (Insured ❑ Self, ❑ Spouse, ❑ Dependent)	ID Number	RXGRP
Pharmacy Benefit Card	RXBIN	Member/Subscriber ID Number	RXGRP	PCN

Additional Information

Today's Date	Start Date	Deliver to: ❑ Home ❑ Physician	Nurse Training Needed? ❑ Yes ❑ No	Special Instructions

Clinical Information

Diagnosis: Date of Diagnosis_____ Patient Weight _____ kg/lbs

❑ 714.0 Rheumatoid Arthritis
❑ 696.0 Psoriatic Arthritis
❑ Other_____
❑ 720.0 Ankylosing Spondylitis
❑ 714.3 Juvenile Idiopathic Arthritis

Prior Medications: ❑ Acetaminophen, ibuprofen or other OTC medications
❑ Enbrel ❑ Humira ❑ Celebrex ❑ Corticosteroids ❑ Indocin
❑ Methotrexate ❑ Naproxen ❑ Azulfidine ❑ Other_____

❑ Yes ❑ No Patient taking Methotrexate?
❑ Yes ❑ No Patient been diagnosed with Heart Failure?
❑ Yes ❑ No Patient been diagnosed with Lymphoma?
❑ Yes ❑ No Has TB test been performed?
❑ Yes ❑ No Has latex allergy?
❑ Yes ❑ No Has tried and failed 8-12 weeks of oral DMARDS?
❑ Yes ❑ No Patient at risk for Hepatitis B infection?
❑ Yes ❑ No If Yes, has treatment been initiated?

Physician's Orders

❑ Cimzia® ❑ 200mg vial ❑ 200mg/1ml prefilled syr

❑ Starting Dose: 400mg SQ on day 1, at week 2 and at week4
❑ Maintenance Dose: 200mg SQ injection every other week
❑ Maintenance Dose: 400mg SQ injection every 4 weeks
❑ Other:_____

Quantity: 28 day supply Refills:_____

❑ Enbrel® ❑ 50mg/ml click autoinjector
❑ 50mg/ml prefilled syringe
❑ 25mg/0.5ml prefilled syringe
❑ 25mg vial

❑ 50mg SQ injection once a week
❑ 25mg SQ injection twice a week
❑ Other:_____

Quantity: 28 day supply Refills:_____

❑ Humira® ❑ 40mg/0.8ml pen
❑ 40mg/0.8ml prefilled syringe
❑ 25mg/0.5ml prefilled syringe

❑ 40mg SQ injection every other week
❑ 20mg SQ injection every other week
❑ Other:_____

Quantity: 28 day supply Refills:_____

❑ Simponi® ❑ 50mg/0.5ml autoinjector
❑ 50mg/0.5ml prefilled syringe

❑ 50mg SQ injection once a month
❑ Other:_____

Quantity: _____ Refills:_____

❑ Orencia® ❑ 250mg vial

❑ Infuse ____mg 100ml of 0.9% NaCl at week 0, 2 and 4 then every 4 weeks thereafter
❑ Other: _____

Quantity: _____ Refills:_____

❑ Remicade® ❑ 100mg vial

❑ Infuse: 250ml IV of 0.9% NaCl, at week 0, 2 and 6
❑ Maintenance Dose: 250ml IV of 0.9% NaCl at 8 weeks
❑ Maintenance Dose: 250ml IV of 0.9% NaCl at 6 weeks
❑ Other:_____

Quantity: _____ Refills:_____

❑ Rituxan® ❑ 100mg/10ml vial
❑ 500mg/50ml vial

❑ Infuse two doses of 1000mg in 1 liter of 0.9%NaCl separated by 2 weeks
❑ Other:_____

Quantity: _____ Refills:_____

❑ Other:_____
Dose:_____
Sig:_____
_____

Quantity: _____ Refills:_____

When sending a referral please include all clinical information, including recent lab values, relevant to performing a prior authorization and copies of patient's insurance cards

Physician Signature:_____ **Date** ____/____/____

I authorize MedQuick Pharmacy and its representatives to act as my agent in order to initiate and execute the insurance prior authorization process and, in doing so, to release clinical information via phone to the appropriate third party payer.