



STAR CARE PHARMACY

"The First Wealth is Health"

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RHEUMATOLOGY REFERRAL FORM

Date: _____ Attn: _____

Ship to Patient Physician Office Nurse/Training

Patient Name _____
 Address _____ Suite# _____
 City _____ State _____ Zip _____
 Home Tel _____ Work Tel _____
 Cell _____ Email _____
 Date of Birth _____ SS# _____
 Male Female Weight _____ Height _____

Prescriber's Name _____
 License# _____ DEA# _____
 NPI# _____ UPIN# _____
 Practice Name _____
 Office Contact _____
 Address _____ Suite# _____
 City _____ State _____ Zip _____
 Tel _____ Fax _____

Insurance Information (Complete or attach copies of cards)

Primary Insurance: _____ Insured's Name: _____
 ID#: _____ City: _____ State: _____ Phone: () _____ - _____
 Group #: _____ Employer: _____

Diagnostic & Clinical Information

ICD-10 Diagnosis Code: L40.59 Psoriatic Arthritis M32.10 SLE M06.9 Rheumatoid Arthritis M45.9 Ankylosing Spondylitis
 M19.90 Osteoarthritis (Unspecified site) M81.0 Osteoporosis (age-related, w/o current fracture) Other _____
 Previously treated for this condition? Yes No Medication(s) failed _____
 Patient currently taking Methotrexate? Yes No For Humira/Enbrel: PPD (TB Test) Yes No
 Does patient have latex allergy (for Enbrel)? Yes No Rheumatoid Factor Positive _____ Total Swollen Joints _____
 For Forteo: T-Score _____ Date _____ Fracture History: Site _____ Date _____

Prescription

HUMIRA® (adalimumab) Patient weight (kg) _____
 Dose: 40mg/0.8mL PFS 40mg/0.8mL PEN
 Dispense: Inject 40mg subcutaneously every OTHER week
 Inject 40mg subcutaneously ONCE a week
 Qty: 4 week supply Refill _____

ENBREL® (etanercept)
 SureClick™ Autoinjector 50mg Prefilled Syringe 50mg
 Multiuse Vial 25mg (injection supplies included)
 Dispense: 1 x week 2 x week Qty: 4 week supply Refill _____

FORTEO® 750ug/3ml Pen Inject 20mcg SQ Daily as directed
 QTY: 4 week supply Refill _____
 B-D 31 gauge 5mm PEN NEEDLES Use as directed w/ Forteo pen
 QTY: 100 (1 box) Refill _____

KINERET® (anakinra) 100mg PFS Inject 100mg (0.67ml) SQ QD
 QTY: 4 week supply Refill _____

ORENCIA® 125mg PFS 250mg Vial 125mg ClickJect™
 Inject 125mg SC weekly
 Infuse _____ mg, _____
 Infuse _____ mg at weeks, 0, 2 and 4, then every 4 weeks thereafter
 Other _____
 QTY: 4 week supply Refill _____ CARTON OF 4 AUTOINJECTORS

RITUXAN® 100mg/10ml Vial 500mg/50ml Vial
 SIG _____
 QTY: _____ # of vials Refill _____

BENLYSTA® 120mg Vial 400mg Vial
 Induction Dose: Inject 10mg/kg SC every 2 weeks for first 3 doses
 Maintenance Dose: Inject 10mg/kg SC every 4 weeks
 QTY: _____ # of vials Refill _____

STELARA®
 Starting Dose: 45mg 90mg
 SQ initially & 4 weeks later
 Maintenance Dose: 45mg 90mg
 SQ every 12 weeks

REMICADE® 100mg Vial 5mg/kg _____ mg/kg
 IV on weeks 0, 2 and 6 (induction)
 IV every 8 weeks (Maintenance Dose)
 IV every _____ weeks
 QTY: _____ # of vials Refill _____

SIMPONI® SmartJect™ PEN 50mg/0.5mL PFS 50mg/0.5mL
 Inject 50mg subcutaneously once per month
 QTY: 1 month supply Refill _____

ACTEMRA® (tocilizumab) 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® 200mg/1ml PFS 50mg/200mg Vial
 Initial Dose: Inject 400mg SQ on day 1, at week 2 & at week 4
 Maintenance Dose: Inject 200mg SQ every OTHER week
 Maintenance Dose: Inject 400mg SQ every OTHER week
 Other _____
 QTY _____ Refill _____

PROLIA® 60mg PFS 60mg Vial
 Inject 60mg subcutaneously every 6 months QTY: 1 Refill _____
RECLAST® 5mg/100ml Vial
 5mg IV once yearly QTY: 1 Refill _____

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

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