

RHEUMATOLOGY PATIENT REFERRAL FORM

Ship to: <input type="checkbox"/> Patient <input type="checkbox"/> Physician 1 st order only <input type="checkbox"/> Physician all orders <input type="checkbox"/> Other _____ <input type="checkbox"/> Educational Support Requested	
Patient Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Home Phone: (____) _____ - _____ Work Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____ Patient Soc. Sec #: _____ Allergies: _____ Date of Birth: ____/____/____ Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female Weight: ____ lbs ____ kg Patient ethnicity: _____ <input type="checkbox"/> See attached demographic sheet Height: _____ BSA _____ m ²	Physician Name: _____ State Lic #: _____ DEA #: _____ NPI #: _____ Specialty: _____ Practice Name/Hospital: _____ Address: _____ City: _____ State: _____ Zip: _____ Physician Phone: _____ Physician Fax: _____ Nurse/Key Office Contact: _____

INSURANCE INFORMATION (Please Attach Copies of front and back of cards)

DIAGNOSTIC INFORMATION COMPLETE FIELDS BELOW AND ATTACH APPROPRIATE DOCUMENTS. Please Fax Concurrent Medication List to Grubb's NW Specialty Pharmacy

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| <input type="checkbox"/> M06.9 Rheumatoid Arthritis | <input type="checkbox"/> L40.59 Other Psoriasis | <input type="checkbox"/> M08.3 Polyarticular Juvenile Rheumatoid Arthritis | <input type="checkbox"/> M08.00 Juvenile Idiopathic Arthritis |
| <input type="checkbox"/> M45.9 Ankylosing Spondylitis | <input type="checkbox"/> M33.20 Polmyositis | <input type="checkbox"/> M15.9 Polyosteoarthritis | <input type="checkbox"/> M19.91 Osteoarthritis, unspecified |
| • Has patient received a PPD (tuberculosis) Skin Test? <input type="checkbox"/> Yes <input type="checkbox"/> No Results: _____ Date: _____
• Has this patient been treated for this condition previously? <input type="checkbox"/> Yes <input type="checkbox"/> No Medication(s): _____
• Is this patient currently on therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No Medication(s): _____
• Will patient stop taking the above medication(s) before starting the new medication? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how long should patient wait before starting the new medication? _____
• If applicable, document the lowest T Score recorded for the patient on the Bone Mineral Density (BMD) Scan.
T Score: _____ Anatomical Location: _____ Date: _____ | | | |

<input type="checkbox"/> Cimzia® <input type="checkbox"/> Initial dose: 400mg SQ weeks 0, 2, 4 <input type="checkbox"/> Maintenance dose: 200mg SQ Q 2Wks <input type="checkbox"/> Maintenance dose: 400mg SQ Q 4Wks QTY: _____ REFILLS: _____ <input type="checkbox"/> Cosentyx® <input type="checkbox"/> 150mg/1ml Pen <input type="checkbox"/> 150mg/1ml PFS <input type="checkbox"/> 300mg/2ml Pen <input type="checkbox"/> 300mg/2ml PFS SIG: <input type="checkbox"/> Starting Dose: Inject SQ weekly for 5 weeks QTY: 5 REFILLS: 0 SIG: <input type="checkbox"/> Maintenance Dose: Inject SQ once a month QTY: _____ REFILLS: _____ <input type="checkbox"/> Forteo® <input type="checkbox"/> 3ml Pen <input type="checkbox"/> Pen Needles 31 gauge _____ mm SIG: <input type="checkbox"/> Inject 20mcg SQ daily as directed QTY: _____ REFILLS: _____ <input type="checkbox"/> Tymlos™ <input type="checkbox"/> 1.56ml Pen <input type="checkbox"/> Pen Needles 31 gauge _____ mm SIG: <input type="checkbox"/> Inject 80mcg SQ daily as directed QTY: _____ REFILLS: _____ <input type="checkbox"/> Orencia® <input type="checkbox"/> 125mg/ml PFS <input type="checkbox"/> 125mg/ml ClickJet SIG: <input type="checkbox"/> 125mg SQ once a week QTY: _____ REFILLS: _____	<input type="checkbox"/> Enbrel® <input type="checkbox"/> 25mg/ml multi-use vial <input type="checkbox"/> 25mg/ml PFS <input type="checkbox"/> 50mg/ml Autoinjector <input type="checkbox"/> 50mg/ml PFS SIG: <input type="checkbox"/> Inject 25mg SQ twice a week <input type="checkbox"/> Inject 50mg SQ once a week <input type="checkbox"/> Alternate Dose _____ <input type="checkbox"/> Humira® 40mg <input type="checkbox"/> Pen <input type="checkbox"/> PFS Citrate Free? <input type="checkbox"/> YES <input type="checkbox"/> NO SIG: <input type="checkbox"/> Starting Dose: _____ QTY: _____ REFILLS: 0 SIG: <input type="checkbox"/> Maintenance Dose: Inject SQ once a week <input type="checkbox"/> Maintenance Dose: Inject SQ every other week QTY: _____ REFILLS: _____ <input type="checkbox"/> Otezla® <input type="checkbox"/> Enroll in BRIDGE RX (see back) <input type="checkbox"/> 2 Week Starter Pack Dispensed by Prescriber Titration Start Date: _____ <input type="checkbox"/> 4 Week Starter Pack QTY: 1 REFILLS: 0 <input type="checkbox"/> Maintenance Dose: 30 mg twice daily <input type="checkbox"/> Alternate Dose: _____ QTY: _____ REFILLS: _____ <input type="checkbox"/> Other _____ SIG: _____ QTY: _____ REFILLS: _____	<input type="checkbox"/> Stelara™ If patient's weight ≤ 220lbs <input type="checkbox"/> 45 mg PFS <input type="checkbox"/> 45 mg/0.5 ml vial If patient's weight ≥ 220lbs <input type="checkbox"/> 90 mg PFS <input type="checkbox"/> 90 mg/ml vial SIG: <input type="checkbox"/> Starting Dose: Inject SQ initially (week 0) QTY: 1 REFILLS: 0 SIG: <input type="checkbox"/> then Inject SQ, on week 4 QTY: 1 REFILLS: 0 SIG: <input type="checkbox"/> Maintenance Dose: Inject SQ every 12 weeks QTY: 1 REFILLS: _____ <input type="checkbox"/> Taltz™ <input type="checkbox"/> 80mg/ml Pen <input type="checkbox"/> 80mg/ml PFS SIG: <input type="checkbox"/> Inject 160mg (2 doses) SQ on week 0 QTY: 2 REFILLS: 0 <input type="checkbox"/> then Inject 80mg SQ once every 4 weeks QTY: 1 REFILLS: _____ For patients with coexistent moderate-to-severe plaque psoriasis, <input type="checkbox"/> Inject 160mg (2 doses) SQ on week 0, then Inject 80mg SQ on weeks 2,4,6,8,10 and 12 QTY: 8 REFILLS: 0 <input type="checkbox"/> then Inject 80mg SQ once every 4 weeks QTY: 1 REFILLS: _____
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Prescriber Prior Authorization Consent: Physician hereby authorizes the Pharmacy, as agent for Physician, to perform any of the following services on behalf of Physician for this Patient: To obtain prior authorization from applicable PBMs or other payors for drugs prescribed by Physician, including, as necessary, the provision of prerequisite clinical and other patient information; to conduct benefits investigations; and to conduct eligibility investigations. In furtherance of the Pharmacy providing the above services, Physician agrees to provide or make available to the Pharmacy from time to time such information regarding patient's treatment as might be requested by payor.

I certify that I am prescribing the drug(s) listed above. I authorize the Pharmacy to perform the above services on behalf of Physician for the benefit of the Patient.

Physician's Signature: _____ DAW (Dispense as Written) Date: ____/____/____
 Prescriber certifies that this referral form contains an original signature and is signed by the treating physician

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1517 17th Street NW, Washington DC 20036

Phone: 202-503-2644 | Fax: 202-503-1721

Our PA Team is here to help! Here is our contact information:
Main number: (202) 503-2644 | Fax number: (202) 503-1721

- To check on status of **pending PAs**, call **Angela** at ext.225
- **All other questions**, call **Dawn** at ext. 221 or **Nick** at ext. 218

❖ **Please forward to us any updates you receive from the insurance company regarding approvals or denials**

Bridge Rx — 30 mg of Otezla†

TWICE DAILY (Recommended daily dose) x 14 days 28 tablets 12 refills

ONCE DAILY (For patients with severe renal impairment) x28 days 28 tablets 6 refills

† Bridge Rx is at no cost, for eligible commercially insured, on-label diagnosed patients only, and not contingent on purchase requirements of any kind. Bridge Rx is not available to enrollees in Medicare, Medicaid, and other federal and state programs, as well as Massachusetts residents. Intended to support continuation of prescribed therapy if there is a delay in determining whether commercial prescription coverage is available

www.grubbsnw.com

Rep: _____

Revised: 12/14/2018