PHARMACY SPECIALISTS
Your Partner in HealthCare

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Rheumatology Referral Form

DATE: **NEEDS BY DATE:** **SHIP TO** (circle one) **PATIENT HOME** **or** **MD OFFICE** **or** **OTHER**_____

PATIENT INFORMATION

Patient Name_____

Address _____

City, State, ZIP _____

Home Phone _____

Alternate Phone_____

Social Security Number _____Gender_____

PRESCRIBER INFORMATION

Prescriber Name_____

Address_____

City, State ZIP _____

Phone_____Fax_____

Contact Person_____

DEA #_____ NPI_____

INSURANCE INFORMATION: (Please send over a copy of the front and back of insurance and prescription cards)

CLINICAL INFORMATION

Diagnosis: ___ 714.0 Rheumatoid Arthritis ___ 696.0 Psoriatic Arthritis ___ 733.0 Osteoporosis ___ 720.0 Ankylosing Spondylitis __Other _____

Previous Medications with outcome:☐ Methotrexate (dose/duration)_____ ☐ Sulfasalazine ☐ NSAIDs

☐ Other DMARDs:_____ ☐ Biologics with dose/duration/outcome (Humira, Enbrel, Remicade) _____

Other Medications:_____ TB Test Date_____ TScore (Forteo/Prolia)_____

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	SIG	QTY	REFILLS
Actemra	N/A	_____	_____	_____
Cimzia Vial	200mg Starter dose	Inject 400mg SQ at weeks 0, 2 and 4	____SIX____	_____
Cimzia Vial	200mg	Inject 400mg SQ Every 4 weeks	___TWO___	_____
Cimzia PFS	200mg Starter dose	Inject 400mg SQ at weeks 0, 2 and 4	____SIX____	_____
Cimzia PFS	200mg	Inject 400mg SQ Every 4 weeks	___TWO___	_____
Enbrel Sureclick	50mg	Inject 50mg SQ Twice a week	___EIGHT___	_____
		Inject 50mg SQ Once a week	___FOUR___	_____
Enbrel PFS	50mg	Inject 50mg SQ Twice a week	___EIGHT___	_____
		Inject 50mg SQ Once a week	___FOUR___	_____
Enbrel PFS	25mg	Inject 25mg SQ Twice a week	___EIGHT___	_____
		Inject 25mg SQ Once a week	___FOUR___	_____
Forteo Pen	20mcg	Inject 20mcg SQ QD	___THREE__	_____
Humira	40mg Starter Kit	Day 1 – Inject 80mg SQ		
		Day 8 – Inject 40mg SQ, then		
		Inject 40mg SQ QOW	__One Kit__	_____
Humira PFS	40mg	Inject 40mg SQ QOW	___TWO___	_____
Humira Pen	40mg	Inject 40mg SQ QOW	___TWO___	_____
Orencia PFS	125mg	Inject 125mg SQ Once a week	___FOUR___	_____
Orencia Vial	250mg Starter dose	Infuse _____mg on Day 1, Day 15 and Day 29	_____	_____
Orencia Vial	250mg	Infuse _____mg Every Month	_____	_____
Prolia	60mg	Inject 60mg SQ Every 6 months	_____	_____
Remicade Vial	100mg	_____	_____	_____
Rituxan	N/A	_____	_____	_____
Simponi SmartJect	50mg	Inject 50mg SQ Every Month	___ONE___	_____
Simponi PFS	50mg	Inject 50mg SQ Every Month	___ONE___	_____
Xeljanz Tablets	5mg	Take 1 tablet by mouth twice a day	_____	_____
Other:				
_____		_____	_____	_____

_____ _____ _____

Prescriber Signature Date Dispense As Written? (Please write DAW)