

# RHEUMATOLOGY

## Referral Form



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Today's Date: \_\_\_\_\_ Needs By Date: \_\_\_\_\_ SHIP TO:  Patient  Office  Other \_\_\_\_\_

PATIENT INFORMATION		PRESCRIBER INFORMATION	
PATIENT NAME		PRESCRIBER NAME	
ADDRESS		NPI#	
CITY, STATE, ZIP		DEA#	LICENSE#
MAIN PHONE#	ALT.#	ADDRESS	
SOCIAL SECURITY#		CITY, STATE, ZIP	
DATE OF BIRTH	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	PHONE#	FAX#
HEIGHT	WEIGHT <input type="checkbox"/> LBS <input type="checkbox"/> KG	CONTACT PERSON	
ALLERGIES			
OTHER MEDICATIONS			

CLINICAL INFORMATION			
<b>Diagnosis:</b> <input type="checkbox"/> M06.9 Rheumatoid Arthritis <input type="checkbox"/> L40.59 Psoriatic Arthritis <input type="checkbox"/> M81.0 Osteoporosis <input type="checkbox"/> M45.9 Ankylosing Spondylitis <input type="checkbox"/> K50.00 Crohn's Disease <input type="checkbox"/> Other: _____			
<b>Prior Failed Meds:</b> <input type="checkbox"/> Methotrexate Length of Treatment _____ Reason for Discontinuing _____ <input type="checkbox"/> _____ Length of Treatment _____ Reason for Discontinuing _____ <input type="checkbox"/> _____ Length of Treatment _____ Reason for Discontinuing _____			
<b>Forteo/Prolia: T--Score</b> _____ Type _____ Date _____		<b>Fracture History:</b> Site _____ Date _____ Site _____ Date _____	
Does patient have a latex allergy? <input type="checkbox"/> Yes <input type="checkbox"/> No TB/PPD Test given or intended to be given before start? <input type="checkbox"/> Yes <input type="checkbox"/> No			

PRESCRIPTION INFORMATION			QUANTITY	REFILLS
<input type="checkbox"/> Actemra®	<input type="checkbox"/> 162mg/0.9ml Prefilled Syringe	Inject 1 syringe SC <input type="checkbox"/> Every Week <input type="checkbox"/> Every Other Week		
<input type="checkbox"/> Cimzia® Starter Dose <input type="checkbox"/> Cimzia® Maintenance	<input type="checkbox"/> 200mg Starter Kit (contains 6, 200mg PFS) <input type="checkbox"/> 2 x 200mg Prefilled Syringe	<input type="checkbox"/> Starter: Inject 400mg SC once, then repeat at weeks 2 and 4 <input type="checkbox"/> Maintenance: <input type="checkbox"/> 200mg SC ONCE every TWO weeks <input type="checkbox"/> 400mg SC ONCE every FOUR weeks		
<input type="checkbox"/> Cosentyx® Starter Dose <input type="checkbox"/> Cosentyx® Maintenance	<input type="checkbox"/> 150 mg/ml Sensoready Pen <input type="checkbox"/> 150 mg/ml Pre-filled Syringe	<input type="checkbox"/> Starter: Inject 150mg SQ on week 0, 1, 2, 3, and 4 (Quantity: 5) <input type="checkbox"/> Maintenance: Inject 150mg SQ every 4 weeks <input type="checkbox"/> Starter: Inject 300 mg SQ on week 0, 1, 2, 3, and 4 (Quantity: 10) <input type="checkbox"/> Maintenance: Inject 300mg SQ every 4 weeks		
<input type="checkbox"/> Enbrel®	<input type="checkbox"/> 50mg/ml SureClick™ Autoinjector <input type="checkbox"/> 50mg/ml Prefilled Syringe <input type="checkbox"/> 25mg/0.5ml Prefilled Syringe	<input type="checkbox"/> Inject 50mg SC ONCE a week <input type="checkbox"/> Inject 25mg TWICE a week, 72 to 96 hours apart <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Forteo®	<input type="checkbox"/> 600mcg/2.4ml PFS	<input type="checkbox"/> Inject 20mcg SC, as directed, once daily		
<input type="checkbox"/> Humira®	<input type="checkbox"/> 40mg/0.8ml Pen <input type="checkbox"/> 40mg/0.8ml Prefilled Syringe	<input type="checkbox"/> Inject 40mg SC every OTHER week <input type="checkbox"/> Inject 40mg SC ONCE a week		
<input type="checkbox"/> Methotrexate®	<input type="checkbox"/> 2.5mg Tablets <input type="checkbox"/> 25mg/ml Injectable Solution	<input type="checkbox"/> Take tablet(s) by mouth every week <input type="checkbox"/> Inject ml SQ every 7 days at the same time each week		
<input type="checkbox"/> Orencia®	<input type="checkbox"/> 125mg/ml Prefilled Syringe (4 syringes)	<input type="checkbox"/> Inject 125mg SC ONCE weekly		
<input type="checkbox"/> Otezla®	<input type="checkbox"/> Starter Pack (Titration) Rx for Otezla <input type="checkbox"/> Maintenance Rx – 30 mg of Otezla <input type="checkbox"/> Bridge Rx – 30 mg of Otezla	<input type="checkbox"/> x28 days 55 tablets <input type="checkbox"/> x14 days 27 tablets <input type="checkbox"/> Twice Daily <input type="checkbox"/> Once Daily (pts. with severe renal impairment) <input type="checkbox"/> Twice Daily <input type="checkbox"/> Once Daily (pts. with severe renal impairment)	<input type="checkbox"/> x30 <input type="checkbox"/> x90 <input type="checkbox"/> x14 <input type="checkbox"/> x28	
<input type="checkbox"/> Otrexup®	<input type="checkbox"/> 10mg Auto Injector <input type="checkbox"/> 12.5mg Auto Injector <input type="checkbox"/> 15mg Auto Injector <input type="checkbox"/> 17.5mg Auto Injector <input type="checkbox"/> 20mg Auto Injector <input type="checkbox"/> 22.5mg Auto Injector <input type="checkbox"/> 25mg Auto Injector	<input type="checkbox"/> Inject ml SQ every week		
<input type="checkbox"/> Rasuvo®	<input type="checkbox"/> 7.5mg Auto Injector <input type="checkbox"/> 10mg Auto Injector <input type="checkbox"/> 12.5mg Auto Injecto <input type="checkbox"/> 15mg Auto Injector <input type="checkbox"/> 17.5mg Auto Injector <input type="checkbox"/> 20mg Auto Injector <input type="checkbox"/> 22.5mg Auto Injecto <input type="checkbox"/> 25mg Auto Injector <input type="checkbox"/> 27.5mg Auto Injector <input type="checkbox"/> 30mg Auto Injector	<input type="checkbox"/> Inject ml SQ every week		
<input type="checkbox"/> Simponi®	<input type="checkbox"/> 50mg/0.5ml Prefilled Syringe <input type="checkbox"/> 50mg/0.5ml Autoinjector	<input type="checkbox"/> Inject 50mg ONCE a month <input type="checkbox"/> Inject 50mg ONCE a month		
<input type="checkbox"/> Stelara®	<input type="checkbox"/> 45mg/0.5ml Prefilled Syringe <input type="checkbox"/> 90mg/ml Prefilled Syringe <input type="checkbox"/> 45mg/0.5ml Single-dose Vial	<input type="checkbox"/> Starter Dose: Inject 45mg SQ on Day 0 and Day 28 <input type="checkbox"/> Maintenance: Inject 45mg SQ every 12 weeks <input type="checkbox"/> Starter Dose: Inject 90mg SQ on Day 0 and Day 28 <input type="checkbox"/> Maintenance: Inject 90mg SQ every 12 weeks		
<input type="checkbox"/> Xeljanz®	<input type="checkbox"/> 5mg <input type="checkbox"/> 11mg (Extended Release Tablets)	<input type="checkbox"/> Take 1 tablet by mouth TWICE daily		
<input type="checkbox"/> Rinvoq®	<input type="checkbox"/> 15mg	<input type="checkbox"/> Take 1 tablet by mouth daily		

**INSURANCE: PLEASE FAX COPY OF PRESCRIPTION CARD & MEDICAL CARD FRONT & BACK**

By signing this form and utilizing our services, you are authorizing MedicoRX and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature (no stamps) If Brand required check  DAW

Initials:

Date:

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