

Phone: 866.892.1580 • Fax: 866.892.2363

RHEUMATOLOGY NON-IV REFERRAL FORM

PATIENT INFORMATION				
Patient Name:	DOB:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other:	Weight:	<input type="checkbox"/> lbs. <input type="checkbox"/> kg.
SSN:	Phone:	Allergies:		
Address:	City:	State:	Zip:	
Emergency Contact:	Phone:	<input type="checkbox"/> Additional information attached		

PRESCRIBER INFORMATION				
Prescriber:	NPI:	DEA:	State Lic:	
Supervising Physician:	Practice Name:			
Address:	City:	State:	Zip:	
Phone:	Fax:	Key Office Contact:	Phone:	

DIAGNOSIS INFORMATION / MEDICAL ASSESSMENT	
Primary Diagnosis: <input type="checkbox"/> M06.9 Rheumatoid Arthritis <input type="checkbox"/> L40.54; L40.59 Psoriatic Arthritis <input type="checkbox"/> M08.00 Polyarticular Juvenile Rheumatoid Arthritis <input type="checkbox"/> M08.00 Juvenile Idiopathic Arthritis <input type="checkbox"/> L40.0 Plaque Psoriasis <input type="checkbox"/> M45.9 Ankylosing Spondylitis <input type="checkbox"/> M33.20 Polymyositis <input type="checkbox"/> M81.0 Osteoporosis <input type="checkbox"/> M15.0; M15.9 Osteoarthritis <input type="checkbox"/> Other: _____	
• Has patient been treated <i>previously</i> for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No Is patient <i>currently</i> on therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No Please list medication(s) and treatment duration: _____	
• 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? _____	
• Other medications patient is currently taking including OTC medications with dosage and direction (or fax medication profile): _____	
• Has patient received a Quatiferon gold, Tspot, or PPD (tuberculosis) Skin Test? <input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____ Results: <input type="checkbox"/> Negative <input type="checkbox"/> Positive <i>Prior to initiating treatment and periodically during therapy, patient should be evaluated for active tuberculosis and tested for latent infection</i>	

PRESCRIPTION INFORMATION	
<input type="checkbox"/> Cimzia® 200 mg/mL Prefilled Syringe <input type="checkbox"/> Cimzia® 200 mg Vial <small>*Cimzia vial should be prepared and administered by a healthcare professional. Prefilled Syringe will be dispensed unless vial is requested.</small> <input type="checkbox"/> Starter Dose: 400 mg SQ (2 inj. of 200 mg) initially (Week 0), repeat at Weeks 2 and 4 <input type="checkbox"/> Maintenance Dose: <input type="checkbox"/> 400 mg SQ (2 inj. of 200 mg) every 4 weeks <input type="checkbox"/> 200 mg SQ every 2 weeks <input type="checkbox"/> Alternate Dose: _____	<input type="checkbox"/> Enroll in Cimplicity™ Program QTY: <u>1 starter kit (6 PFS)</u> Refills: <u>0</u> QTY: <u>1 box (2 inj.)</u> Refills: _____ QTY: _____ Refills: _____
<input type="checkbox"/> Cosentyx® 150 mg/mL Prefilled Syringe <input type="checkbox"/> Cosentyx® 150 mg/mL Sensoready Pen <input type="checkbox"/> Starter Dose: 150 mg SQ at Weeks 0, 1, 2, 3 and 4 <input type="checkbox"/> Starter Dose: 300 mg SQ at Weeks 0, 1, 2, 3 and 4 <input type="checkbox"/> Maintenance Dose: 150 mg SQ every 4 weeks <input type="checkbox"/> Maintenance Dose: 300 mg SQ every 4 weeks <input type="checkbox"/> Alternate Dose: _____	QTY: _____ Refills: <u>0</u> QTY: _____ Refills: <u>0</u> QTY: _____ Refills: _____ QTY: _____ Refills: _____
<input type="checkbox"/> Enbrel® 50 mg/mL Sureclick (Autoinjector) <input type="checkbox"/> Enbrel® 50 mg/mL Prefilled Syringe <small>*Not to be used in pediatric weighing less than 63 kg (138 lb.)</small> <input type="checkbox"/> 50 mg SQ weekly <input type="checkbox"/> Alternate Dose: _____	<input type="checkbox"/> Enroll in Enliven® Program QTY: <u>4</u> Refills: _____ QTY: _____ Refills: _____
<input type="checkbox"/> Enbrel® 25 mg/ 0.5 mL Prefilled Syringe <input type="checkbox"/> 25 mg SQ BIW (72-96 hours apart) <input type="checkbox"/> Alternate Dose: _____	QTY: <u>8</u> Refills: _____ QTY: _____ Refills: _____
<input type="checkbox"/> Humira® 40 mg/ 0.4 mL Pen CF NDC: 0074-0554-02 <input type="checkbox"/> Humira® 40 mg/ 0.4 mL Prefilled Syringe CF NDC: 0074-0243-02	<input type="checkbox"/> Enroll in Humira Complete Program
<input type="checkbox"/> Humira® 20 mg/ 0.4 mL Prefilled Syringe CF <input type="checkbox"/> Humira® 10 mg/ 0.2 mL Prefilled Syringe CF <input type="checkbox"/> 40 mg SQ every other week <input type="checkbox"/> 20 mg SQ every other week <input type="checkbox"/> 10 mg SQ every other week <input type="checkbox"/> 40 mg SQ every week <input type="checkbox"/> Alternate Dose: _____	QTY: _____ Refills: _____ QTY: _____ Refills: _____
<input type="checkbox"/> Kevzara® Inj. (Sarilumab) Single Prefilled Syringe <input type="checkbox"/> Kevzara® Inj. (Sarilumab) Single Prefilled Pen <input type="checkbox"/> 150 mg/1.14 mL <input type="checkbox"/> 200 mg/1.14 mL <input type="checkbox"/> 1 SQ inj. every 2 weeks	Days' Supply: <input type="checkbox"/> 30 <input type="checkbox"/> 90 QTY: _____ Refills: _____
<input type="checkbox"/> Otezla Tablet <input type="checkbox"/> Five (5) day titration period: day 1: 10 mg, day 2: 10 mg BID, day 3: 10 mg then 20 mg BID, day 4: 20 mg BID, day 5: 20 mg then 30 mg BID <input type="checkbox"/> After five (5) day titration period, 30 mg BID	QTY: _____ Refills: _____ QTY: _____ Refills: _____
<input type="checkbox"/> Orencia® 125 mg/mL SQ Prefilled Syringe (and 250 mg Vial for Starter Dose) <input type="checkbox"/> Orencia® 125 mg/mL ClickJect (Autoinjector) for SQ <input type="checkbox"/> Starter Dose: One dose of IV infusion (per body weight) <input type="checkbox"/> Less than 60 kg, dose: 500 mg <input type="checkbox"/> 60-100 kg, dose: 750 mg <input type="checkbox"/> Greater than 100 kg, dose: 1000 mg then 125 mg SQ with a day of IV followed by 125 mg SQ every week after <input type="checkbox"/> Maintenance Dose: 125 mg SQ every week <input type="checkbox"/> Other: _____	<input type="checkbox"/> Enroll in Orencia OnCall Program QTY: <u>28 day QS for 1 IV dose and SQ (4 syringes)</u> Refills: <u>0</u> QTY: _____ Refills: _____ QTY: _____ Refills: _____

Prescriber's Signature: _____ DAW (Dispense as Written) **Date:** _____

Prescriber certifies that this referral form contains an original signature and is signed by the treating prescriber. NO STAMPED SIGNATURES WILL BE ACCEPTED. Where required by law, send prescription on official state prescription blank. In the event requested agent is not available through AcariaHealth, this prescription shall be forwarded to an eligible pharmacy.

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Date Shipment Needed: _____ Ship To: Patient Prescriber

Nursing needed; Training needed ► All the supplies including syringes and needles will be dispensed if needed.

Note: Patients transitioning from Orencia IV to Orencia SQ. Administer the first SQ dose instead of the next scheduled IV dose.

PATIENT INFORMATION			
Patient Name:			DOB:
Address:	City:	State:	Zip:
INSURANCE INFORMATION			
<input type="checkbox"/> Please attach front and back of patient's insurance card (medical and prescription)			
COPAY CARD ENROLLMENT			
<input type="checkbox"/> Please check if enrolling in copay card		Copay ID:	
PRESCRIPTION INFORMATION			
<input type="checkbox"/> Rinvoq® 15 mg Oral Tablet			
Take one tablet orally once daily with or without food		QTY: <u> 30 </u>	Refills: <u> </u>
<input type="checkbox"/> Siliq® 210 mg/1.5 mL Prefilled Syringe			
210 mg SQ at Weeks 0, 1, 2 followed by 210 mg once every 2 weeks		QTY: <u> </u>	Refills: <u> </u>
<input type="checkbox"/> Skyriz® 150 mg/ml Pen <input type="checkbox"/> Skyrizi® 150 mg/ml Prefilled Syringe			
<input type="checkbox"/> Inj. 150mg SQ at week 0		QTY: <u> 1 </u>	Refills: <u> 0 </u>
<input type="checkbox"/> Inj. 150mg SQ every 12 weeks (starting at week 4)		QTY: <u> 1 </u>	Refills: <u> </u>
<input type="checkbox"/> Simponi® 50 mg/0.5 mL SmartJect (Autoinjector) <input type="checkbox"/> Simponi® 50 mg/0.5 mL Prefilled Syringe			
<input type="checkbox"/> 50 mg SQ every month		<input type="checkbox"/> Enroll in SimponiOne Program	
<input type="checkbox"/> Alternate Dose: _____		QTY: <u> </u>	Refills: <u> </u>
<input type="checkbox"/> 80 mcg SQ once daily		QTY: <u> </u>	Refills: <u> </u>
<input type="checkbox"/> Xeljanz® 5 mg Tablet			
<input type="checkbox"/> 5 mg PO BID		QTY: <u> </u>	Refills: <u> </u>
<input type="checkbox"/> 5 mg PO QD		QTY: <u> </u>	Refills: <u> </u>
<input type="checkbox"/> Xeljanz® XR 11 mg Tablet			
<input type="checkbox"/> 11 mg PO QD (can begin the day after the last dose of 5 mg IR)		QTY: <u> </u>	Refills: <u> </u>
<input type="checkbox"/> Other: _____		QTY: <u> </u>	Refills: <u> </u>

Physician's Signature: _____ DAW (Dispense as Written) **Date:** _____

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