Phone: 800.511.5144 • Fax: 877.541.1503

Date Shipment Needed: _____ Ship To: ☐ Patient ☐ Prescriber
☐ Nursing needed; ☐ Training needed ▶ All the supplies including syringes and needles will be dispensed if needed.

RHEUMATOLOGY NON-IV REFERRAL FORM A-OL

PATIENT INFORMATION

Patient Name:		DOB:	Sex: ☐ M ☐ F ☐ Other:	Weight:	☐ lbs. ☐ kg.
SSN:	Phone:	Allergies:			
Address:		City:	State:	Zip:	
Emergency Contact:		Phone:	☐ **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: ☐ M06.9 Rheumatoid Arthritis ☐ L40.54; L40.59 Psoriatic Arthritis ☐ M08.00 Unspecified Juvenile Rheumatoid Arthritis ☐ M08.3 Juvenile Rheumatoid Polyarthritis (Seronegative)
☐ M08.20 Juvenile Idiopathic Arthritis ☐ M45.9 Ankylosing Spondylitis ☐ M33.20 Polymyositis ☐ M81.0 Osteoporosis ☐ M15.0; M15.9 Osteoarthritis ☐ Other:_____

- Has patient been treated *previously* for this condition? ☐ Yes ☐ No Is patient *currently* on therapy? ☐ Yes ☐ No Please list medication(s) and treatment duration:
  _____
- Will patient stop taking the above medication(s) before starting the new medication? ☐ Yes ☐ 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**? ☐ Yes ☐ No Date: _____ Results: ☐ Negative ☐ Positive
  Prior to initiating treatment and periodically during therapy, patient should be evaluated for active tuberculosis and tested for latent infection

INSURANCE INFORMATION

☐ **Please attach front and back of patient's insurance card (medical and prescription)**

COPAY CARD ENROLLMENT

☐ **Please check if enrolling in copay card** **Copay ID:**

PRESCRIPTION INFORMATION

☐ **Actemra® 162 mg** ☐ **Pen** ☐ **Prefilled Syringe**
- ☐ <100 kg: 162 mg SQ once every other week — QTY: 2 Pens / Syringes | Refills:
- ☐ ≥100 kg: 162 mg SQ once every week — QTY: 4 Pens / Syringes | Refills:

☐ **Cimzia® 200 mg/mL Prefilled Syringe** ☐ **Cimzia® 200 mg Vial** ☐ Starter Dose Not Needed ☐ **Enroll in Cimplicity™ Program**
**Cimza vial should be prepared and administered by a healthcare professional. Prefilled Syringe will be dispensed unless vial is requested.*
- *Starter Dose:* ☐ 400 mg SQ (2 inj. of 200 mg) initially (Week 0), repeat at Weeks 2 and 4 — QTY: 1 Starter Kit (6 PFS) | Refills: 0
- *Maintenance Dose:* ☐ 400 mg SQ (2 inj. of 200 mg) every 4 weeks ☐ 200 mg SQ every 2 weeks — QTY: 1 Box (2 INJ.) | Refills:
- *Alternate Dose:* ☐ _____ — QTY: _____ | Refills:

☐ **Cosentyx® 150 mg/mL Prefilled Syringe** ☐ **Cosentyx® 150 mg/mL Sensoready Pen** ☐ **Cosentyx® 300 mg/2 mL UnoReady Pen**
- *Starter Dose:* ☐ 150 mg SQ at Weeks 0, 1, 2, 3 ☐ 300 mg SQ at Weeks 0, 1, 2, 3 ☐ Starter Dose Not Needed — QTY: QS 28 Day Supply | Refills: 0
- *Maintenance Dose:* ☐ 150 mg SQ every 4 weeks (starting at Week 4) ☐ 300 mg SQ every 4 weeks (starting at Week 4) — QTY: QS 28 Day Supply | Refills:

☐ **Enbrel® 50 mg/mL Sureclick (Autoinjector)** ☐ **Enbrel® 50 mg/mL Prefilled Syringe** **Not to be used in pediatric weighing less than 63 kg (138 lb.)* ☐ **Enroll in Enliven® Program**
- ☐ 50 mg SQ weekly — QTY: 4 | Refills:
- ☐ *Alternate Dose:* _____ — QTY: _____ | Refills:

☐ **Enbrel® 25 mg/0.5 mL Prefilled Syringe**
- ☐ 25 mg SQ twice weekly (72-96 hours apart) — QTY: 8 | Refills:
- ☐ *Alternate Dose:* _____ — QTY: _____ | Refills:

☐ **Humira® 40 mg/0.4 mL Pen CF** ☐ **Humira® 40 mg/0.4 mL Prefilled Syringe CF** ☐ **Enroll in Humira Complete Program**
- ☐ Inject 40 mg SQ every other week ☐ Inject 40 mg SQ every week — QTY: _____ | Refills:

☐ **Humira® 10 mg/0.2 mL Prefilled Syringe CF** ☐ **Humira® 20 mg/0.4 mL Prefilled Syringe CF** — QTY: _____ | Refills:
- ☐ Inject 10 mg SQ every other week ☐ Inject 20 mg SQ every other week — QTY: _____ | Refills:

☐ **Ilaris® 150 mg SDV Inj. _____ mg SQ every _____ Weeks** — QTY: _____ | Refills:

☐ **Ilaris® 150 mg/mL Single Dose Vial**
- ☐ Inject 4 mg/kg _____ mg SQ every 4 weeks (300 mg/dose maximum) — QTY: _____ | Refills:

☐ **Kevzara® Inj. Single Prefilled Syringe** ☐ **Kevzara® Inj. Single Prefilled Pen**
- ☐ 150 mg/1.14 mL ☐ 200 mg/1.14 mL ☐ 1 SQ inj. every 2 weeks — QTY: _____ | Refills:

☐ **Olumiant® 2 mg Tablet** ☐ **1 mg Tablet**
- ☐ Take 2 mg tablet PO once daily — QTY: _____ | Refills:
- ☐ Take 1 mg tablet PO once daily — 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 electronic prescription or on official state prescription blank. In the event requested agent is not available through AcariaHealth, this prescription shall be forwarded to an eligible pharmacy.

Date Shipment Needed: _____ Ship To: ☐ Patient ☐ Prescriber
☐ Nursing needed; ☐ Training needed ▶ All the supplies including syringes and needles will be dispensed if needed.

RHEUMATOLOGY NON-IV REFERRAL FORM OM-Z

PATIENT INFORMATION

Patient Name:		DOB:	Sex: ☐ M ☐ F ☐ Other:	Weight:	☐ lbs. ☐ kg.
SSN:	Phone:	Allergies:			
Address:		City:	State:	Zip:	
Emergency Contact:		Phone:	☐ **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: ☐ M06.9 Rheumatoid Arthritis ☐ L40.54; L40.59 Psoriatic Arthritis ☐ M08.00 Unspecified Juvenile Rheumatoid Arthritis ☐ M08.3 Juvenile Rheumatoid Polyarthritis (Seronegative)
☐ M08.20 Juvenile Idiopathic Arthritis ☐ M45.9 Ankylosing Spondylitis ☐ M33.20 Polymyositis ☐ M81.0 Osteoporosis ☐ M15.0; M15.9 Osteoarthritis ☐ Other:_____

- Has patient been treated *previously* for this condition? ☐ Yes ☐ No Is patient *currently* on therapy? ☐ Yes ☐ No Please list medication(s) and treatment duration:
- Will patient stop taking the above medication(s) before starting the new medication? ☐ Yes ☐ 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**? ☐ Yes ☐ No Date: _____ Results: ☐ Negative ☐ Positive
  Prior to initiating treatment and periodically during therapy, patient should be evaluated for active tuberculosis and tested for latent infection

INSURANCE INFORMATION

☐ **Please attach front and back of patient's insurance card (medical and prescription)**

COPAY CARD ENROLLMENT

☐ **Please check if enrolling in copay card** **Copay ID:**

PRESCRIPTION INFORMATION

☐ **Otezla® Tablet** ☐ Five (5) day titration period: **Day 1:** 10 mg, **Day 2:** 10 mg BID, **Day 3:** 10 mg in AM then 20 mg in PM, **Day 4:** 20 mg BID, **Day 5:** 20 mg in AM then 30 mg in PM — QTY: 1 Kit | Refills: 0
☐ After five (5) day titration period, 30 mg BID — QTY: 60 Tablets | Refills:

☐ **Orencia® 125 mg Prefilled Syringe** ☐ **Orencia® 125 mg ClickJect Autoinjector** ☐ **Enroll in Orencia OnCall Program**
☐ *Starter Dose:* One dose of IV infusion (per body weight) ☐ IV Starter Dose Not Needed
☐ < 60 kg: 500 mg IV x 1 dose — QTY: 2 x 250 mg Vial | Refills: 0
☐ 60 - 100 kg: 750 mg IV x 1 dose — QTY: 3 x 250 mg Vial | Refills: 0
☐ > 100 kg: 1000 mg IV x 1 dose — QTY: 4 x 250 mg Vial | Refills: 0
☐ *Maintenance Dose:* 150 mg SQ every week — QTY: 4 PFS / Pens | Refills:

☐ **Rinvoq® 15 mg Oral Tablet**
Take one tablet orally once daily with or without food — QTY: 30 | Refills:

☐ **Siliq® 210 mg / 1.5 mL Prefilled Syringe**
☐ 210 mg SQ at Weeks 0, 1, 2 — QTY: 2 Pens | Refills: 0
☐ 210 mg SQ every 2 weeks (starting at week 2) — QTY: 2 Pens | Refills:

☐ **Skyrizi® 150 mg / mL Pen** ☐ **Skyrizi® 150 mg / mL Prefilled Syringe**
☐ Inj. 150 mg SQ at Week 0 — QTY: 1 | Refills: 0
☐ Inj. 150 mg SQ every 12 weeks (starting at Week 4) — QTY: 1 | Refills:

☐ **Simponi® 50 mg / 0.5 mL SmartJect (Autoinjector)** ☐ **Simponi® 50 mg / 0.5 mL Prefilled Syringe** ☐ **Enroll in SimponiOne Program**
☐ 50 mg SQ every month — QTY: | Refills:
☐ *Alternate Dose:* _____ — QTY: | Refills:

☐ **Taltz® 80 mg / mL** ☐ **Pen** ☐ **Prefilled Syringe** ☐ Starter Dose Not Needed
Starter Dose: ☐ Inject 160 mg once SQ on Week 0 — QTY: 2 | Refills:
Maintenance Dose: ☐ Inject 80 mg once SQ every 4 weeks — QTY: 1 Pen / 1 Syringe | Refills:

☐ **Tremfya® 100 mg / mL** ☐ **Pen** ☐ **Prefilled Syringe** ☐ Starter Dose Not Needed
Starter Dose: ☐ 100 mg SQ at Week 0 and Week 4 — QTY: 1 Pen / 1 Syringe | Refills: 0
Maintenance Dose: ☐ Inject 80 mg SQ once every 4 weeks (starting at Week 4) — QTY: 1 Pen / 1 Syringe | Refills:

☐ **Xeljanz® 5 mg Tablet**
☐ 5 mg PO BID — QTY: | Refills:

☐ **Xeljanz® XR 11 mg Tablet**
☐ 11 mg PO once daily — QTY: | Refills:

☐ **Other:** _____ — 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 electronic prescription or on official state prescription blank. In the event requested agent is not available through AcariaHealth, this prescription shall be forwarded to an eligible pharmacy.