

## RHEUMATOLOGY REFERRAL FORM

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Needs by Date: \_\_\_\_\_

Language: \_\_\_\_\_  Nursing Instruction Required

Ship to:  Patient  MD Office

Prescriber's Name: \_\_\_\_\_ DEA #: \_\_\_\_\_ NPI: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Office Contact: \_\_\_\_\_

### PATIENT INFORMATION: Please complete the following or send patient demographic sheet

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender:  F  M

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Alternate: \_\_\_\_\_ Email: \_\_\_\_\_

### PLEASE ATTACH ALL PRIMARY AND SECONDARY INSURANCE INFORMATION

DIAGNOSIS	CLINICAL INFORMATION FORTEO/PROLIA	LABS																										
<input type="checkbox"/> M06.9 Rheumatoid Arthritis <input type="checkbox"/> M45.9 Ankylosing Spondylitis <input type="checkbox"/> M32.10 Systemic Lupus Erythematosus <input type="checkbox"/> L40.8 Psoriasis Moderate to Severe Plaque <input type="checkbox"/> L40.50 Psoriatic Arthritis <input type="checkbox"/> K50.90 Chron's Disease <input type="checkbox"/> M81.0 Osteoporosis <input type="checkbox"/> Other _____ DX code _____ Diagnosis Date _____	T-Score _____ Type _____ Date _____ Does patient have latex allergy? <input type="checkbox"/> Yes <input type="checkbox"/> No <table border="1"> <thead> <tr> <th colspan="2">PREVIOUS MEDICATIONS/THERAPIES</th> </tr> <tr> <th>Medication</th> <th>Duration of treatment/Reason for discontinuation</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> Methotrexate</td> <td></td> </tr> <tr> <td><input type="checkbox"/></td> <td></td> </tr> <tr> <td><input type="checkbox"/></td> <td></td> </tr> <tr> <td><input type="checkbox"/></td> <td></td> </tr> <tr> <td><input type="checkbox"/></td> <td></td> </tr> </tbody> </table>	PREVIOUS MEDICATIONS/THERAPIES		Medication	Duration of treatment/Reason for discontinuation	<input type="checkbox"/> Methotrexate		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		Has TB test been performed? <input type="checkbox"/> Yes (please attach results) <input type="checkbox"/> No Lab Date: _____ TB Results: _____ <table border="1"> <thead> <tr> <th colspan="2">FRACTURE HISTORY</th> </tr> <tr> <th>Site</th> <th>Date</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> </tr> </tbody> </table>	FRACTURE HISTORY		Site	Date								
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### PRESCRIPTION INFORMATION

MEDICATION	DOSAGE & DIRECTIONS	QUANTITY/DURATION	REFILLS
<input type="checkbox"/> ACTEMRA (tocilizumab)	<input type="checkbox"/> 162mg prefilled syringe - Inject subcutaneously ONCE a week Every OTHER week <input type="checkbox"/> _____ vial - Infuse _____ mg at _____	<input type="checkbox"/> 4-Weeks supply	
<input type="checkbox"/> CIMZIA (certolizumab pegol) <input type="checkbox"/> 200mg x 2 prefilled syringe <input type="checkbox"/> 200mg x 2 LYO powder	<input type="checkbox"/> Starter Kit: Inject 400mg subcutaneously at weeks 0, 2, and 4 <input type="checkbox"/> Maintenance: Inject 400mg subcutaneously ONCE a MONTH <input type="checkbox"/> Maintenance: Inject 200mg subcutaneously ONCE every 2 weeks	<input type="checkbox"/> 4-Weeks supply	
<input type="checkbox"/> COSENTYX (secukinumab) <input type="checkbox"/> 150mg syringe <input type="checkbox"/> 150mg pen	<input type="checkbox"/> Psoriatic arthritis induction (optional): 150mg subcutaneously at weeks 0, 1, 2, 3, and 4 <input type="checkbox"/> Psoriatic arthritis maintenance: 150mg subcutaneously every 4 weeks <input type="checkbox"/> Ankylosing spondylitis induction (optional): 150mg subcutaneously at weeks 0, 1, 2, 3, and 4 <input type="checkbox"/> Psoriatic arthritis maintenance: 150mg subcutaneously every 4 weeks <input type="checkbox"/> Other:	<input type="checkbox"/> Enter quantity _____	
<input type="checkbox"/> ENBREL (etanercept) <input type="checkbox"/> 50mg prefilled syringe <input type="checkbox"/> 50mg SureClick	<input type="checkbox"/> Inject 50mg subcutaneously ONCE a week <input type="checkbox"/> Inject 25mg subcutaneously TWICE a week 72-96 hours apart	<input type="checkbox"/> 4-Weeks supply	
<input type="checkbox"/> FORTEO (teriparatide rDNA origin)	<input type="checkbox"/> Multi-dose prefilled pen - Inject 20mcg subcutaneously ONCE daily	<input type="checkbox"/> 4-Weeks supply	
<input type="checkbox"/> HUMIRA (adalimumab) <input type="checkbox"/> 40mg/0.8ml pen <input type="checkbox"/> 40mg/0.8ml prefilled syringe	<input type="checkbox"/> Inject 40mg subcutaneously every OTHER week <input type="checkbox"/> Inject 40mg subcutaneously ONCE a week	<input type="checkbox"/> 4-Weeks supply	
<input type="checkbox"/> KEVZARA® <input type="checkbox"/> 150mg/1.14ml PFS <input type="checkbox"/> 200mg/1.14ml PFS	<input type="checkbox"/> Inject 200mg SC ONCE every 2 weeks <input type="checkbox"/> Other:	<input type="checkbox"/> 4-Weeks supply	
<input type="checkbox"/> ORENCIA (abatacept) <input type="checkbox"/> 125mg prefilled syringe <input type="checkbox"/> 250mg vials	<input type="checkbox"/> Inject 125mg subcutaneously ONCE a week <input type="checkbox"/> Infuse _____ mg at _____	<input type="checkbox"/> 4-Weeks supply	
<input type="checkbox"/> OTEZLA (apremilast) <input type="checkbox"/> Starter pack <input type="checkbox"/> 30mg tablets	<input type="checkbox"/> Starter pack: Initial titration over 5 days <input type="checkbox"/> Maintenance: Take 1 tablet by mouth twice daily	<input type="checkbox"/> 1 Starter pack <input type="checkbox"/> 60 tablets	
<input type="checkbox"/> PROLIA (denosumab)	<input type="checkbox"/> 60mg syringe: Inject 60mg subcutaneously once every 6 months	<input type="checkbox"/> 4-Weeks supply	
<input type="checkbox"/> REMICADE (infliximab)	<input type="checkbox"/> Infuse _____ mg at _____	<input type="checkbox"/> 4-Weeks supply	
<input type="checkbox"/> RITUXAN (rituximab)	<input type="checkbox"/> Infuse _____ mg at _____	<input type="checkbox"/> 4-Weeks supply	
<input type="checkbox"/> SIMPONI (golimumab) <input type="checkbox"/> 50mg SmartJect <input type="checkbox"/> ARIA <input type="checkbox"/> PFS	<input type="checkbox"/> Inject 50mg subcutaneously ONCE a MONTH as directed <input type="checkbox"/> Infuse _____ mg at weeks 0 and 4, then every 12 weeks	<input type="checkbox"/> 4-Weeks supply	
<input type="checkbox"/> STELARA (ustekinumab) <input type="checkbox"/> 45mg prefilled syringe <input type="checkbox"/> 90mg syringe	<input type="checkbox"/> Inject 45mg on day 0, then week 4, then every 12 weeks <input type="checkbox"/> Inject 90mg subcutaneously ONCE a MONTH as directed	<input type="checkbox"/> 4-Weeks supply	
<input type="checkbox"/> TYMLOS (abaloparatide)	<input type="checkbox"/> Inject 80mcg subcutaneously ONCE daily	<input type="checkbox"/> Enter quantity _____	
<input type="checkbox"/> XELJANZ (tofacitinib citrate)	<input type="checkbox"/> 5mg tablet - Take 1 by mouth TWICE daily	<input type="checkbox"/> 60 tablets	
<input type="checkbox"/> OTHER			

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**IMPORTANT NOTICE:** This facsimile is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the center at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitter material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee.

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