866 413-3156 toll free phone
877 834-1231 toll free fax
QUESTIONS? Please contact us!
www.REPharmacy.com

Rheumatology Prescription Referral Form (A-K)

Send your Rx to: (optional) ______________________

Date Medication Needed: __________ Ship To: ( ) Patient's Home ( ) Prescriber's Office ( ) Pick-up (store location): __________ Injection training by pharmacy? ☐

1. Patient Information

Patient Name: __________ Birthdate: __________ Sex: ( ) Male ( ) Female Height: ______ Weight: ______ ( ) lbs. ( ) kg.

Soc. Sec. #: __________ Preferred Phone: __________ Known Allergies: __________

Address: __________ City: __________ State: ______ Zip: ______

Alternate Caregiver Name: __________ Preferred Phone: __________

2. Insurance Information

Please include copies of the FRONT and BACK of ALL insurance cards (prescription and medical) with this fax.

3. Prescriber Information

Provider Name: __________ DEA#: __________ NPI#: __________ Tax ID#: __________

Address: __________ Phone: __________ Fax: __________

City, State, Zip: __________ Key Contact: __________ Phone: __________

4. Diagnosis/Clinical Information

Please FAX recent clinical notes, labs, tests, with the prescription to expedite the prior authorization.

Diagnosis: __________

Other: __________

Prior failed medications **(medication and duration of treatment/reason for d/c):**

☐ __________

Is patient currently on RA therapy? ( ) Yes ( ) No

Medications: __________

TB/PPD test given? ( ) Yes ( ) No

BMD/T-score: __________ **Date:** __________

Does patient have a latex allergy? ( ) Yes ( ) No

Is Patient at risk for osteoporotic fracture as evident by any of the following?

☐ History of osteoporotic fracture Site: __________ Date: __________

☐ Patient has tried and failed an oral bisphosphonate

☐ Patient has documented contraindication/is intolerant to oral bisphosphonate therapy (please submit a copy of DEXA w/prescription)

5. Prescription Information | *Xeljanz NOT to be used in combination with biologic DMARD's*

Medication	Dose/Strength	Sig	Qty.	Refills
☐ **Actemra®** (Tocilizumab)	☐ 80mg/4ml ☐ 200mg/10ml ☐ 400mg/20ml ☐ 162mg/0.9ml	☐ 4mg/kg IV once every 4 weeks		
☐ **Cimzia®** 200mg/ml	☐ 400mg	☐ 2 injections of 200mg subcutaneously, initially and at weeks 2 and 4 Maintenance: 200mg every other week; 400mg every 4 weeks		
☐ **Enbrel®** (Etanercept)	☐ 50mg/ml SureClick™ Autoinjector	☐ Inject 50mg subcutaneously once a week		
☐ **Humira®** Injection training from *My Humira*	☐ 40mg/0.8ml Pen ☐ 40mg/0.8ml Prefilled Syringe	☐ Inject 40mg subcutaneously every other week ☐ Inject 40mg subcutaneously once a week		
☐ **Kevzara®** (Sarilumab)	☐ 150mg/1.14 ☐ 200mg/1.14ml	☐ 200mg subcutaneously once every 2 weeks		
☐ **Kineret®** (Anakinra)	☐ 100mg/0.67ml	☐ __________ mg/kg per day subcutaneously		
☐ **Other:**				

6. Patient Support Programs

Please sign and date below to enroll in the pharmaceutical company assisted patient support program.

__________ __________

Patient Signature **Date**

7. Prescriber Signature

Prescriber, please sign and date below.

By signing below, the prescriber gives consent to both, the prescription(s) above, as well as to RE Pharmacy to act as the prescriber's agent to begin and execute prior authorization process and to help patient apply to co-pay assistance programs, including all foundations and manufacturer assistance programs if necessary.

__________ __________ __________ __________

Dispense as written **Date** **Substitution Permissible** **Date**

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately. In no event should such material be read or retained by anyone other than the named addressee, except by express authorization of the sender to the named addressee. **Pursuant to VA/OH/MO/VT law, only 1 medication is permitted per order form. Please use a new form for additional items.**

# of Prescriptions: __________

Faxed prescriptions will only be accepted from a prescribing practitioner. Prescribers are reminded patients may choose any pharmacy of their choice.

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