RE PHARMACY
PASSION FOR LIFE

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

# Rheumatology Prescription Referral Form (L-R)

***Send your Rx to:*** (optional)
Select Location

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 |
|---|---|---|---|---|
| ☐ **Leflunomide®** (Arava) | ☐ 10mg or ☐ 20mg | ☐ 20mg once a day | | |
| ☐ **LLaris®** (Kanakinumab) | ☐ 150mg/ml | ☐ 4mg/kg subcutaneously every 4 weeks | | |
| ☐ **Methotrexate®** | ☐ Oral dose _____ Disp.#_____ | ☐ 7.5mg once a week.<br>☐ 2.5mg each 12 hours x3 dose per week | | |
| ☐ **Orencia®** (Abatacept) | ☐ 250mg Disp. # _____ | ☐ 125mg once weekly | | |
| ☐ **Otezla®** (Apremilast) | ☐ 30mg tabs | ☐ 10mg in the morning on day 1, then titrate _____ then 30mg bid on day 6<br>***Please use Otezla-specific referral form available at repharmacy.com*** | | |
| ☐ **Remicade®** (Infliximab) | ☐ 100mg Disp. # _____ | ☐ 3mg/kg as an IV induction regimen at 0, 2, and 6 weeks | | |
| ☐ **Rituxan®** (Rituximab) | _____ | ☐ Two 1,000 mg IV infusions separated by 2 weeks in combination with methotrexate | | |
| ☐ **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** _____



**# of Prescriptions:** _____

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