



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

Rheumatology Prescription Referral Form (S-Z)

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: _____ BMD/T-score: _____ Date: _____
 Other: _____ Does patient have a latex allergy? () Yes () No
 Prior failed medications (medication and duration of treatment/reason for d/c): _____
 _____ Is Patient at risk for osteoporotic fracture as evident by any of the following?
 Is patient currently on RA therapy? () Yes () No
 History of osteoporotic fracture Site: _____ Date: _____
 Medications: _____
 Patient has tried and failed an oral bisphosphonate
 TB/PPD test given? () Yes () No
 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
<input type="checkbox"/> Simponi® (Golimumab)	<input type="checkbox"/> 50mg/0.5ml <input type="checkbox"/> 100mg/ml	<input type="checkbox"/> 50mg subcutaneously once a month		
<input type="checkbox"/> Simponi Aria®	<input type="checkbox"/> 50mg/4ml	<input type="checkbox"/> 2mg/kg intravenously (IV) at weeks 0 and 4, then every 8 weeks thereafter		
<input type="checkbox"/> Stelara® (Ustekinumab)	<input type="checkbox"/> 45mg/0.5ml <input type="checkbox"/> 90mg/ml Disp.# _____	<input type="checkbox"/> 45mg subcutaneously initially and 4 weeks later, and then 45mg every 12 weeks thereafter (100kg)		
<input type="checkbox"/> Xeljanz® (Tofacitinib)	<input type="checkbox"/> 5mg Disp. #60	<input type="checkbox"/> 1 tab bid		
<input type="checkbox"/> Xeljanz XR®	<input type="checkbox"/> 11mg	<input type="checkbox"/> 11mg once daily		
<input type="checkbox"/> 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: _____