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 (S-Z)

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
☐ **Simponi®** (Golimumab)	☐ 50mg/0.5ml ☐ 100mg/ml	☐ 50mg subcutaneously once a month		
☐ **Simponi Aria®**	☐ 50mg/4ml	☐ 2mg/kg intravenously (IV) at weeks 0 and 4, then every 8 weeks thereafter		
☐ **Stelara®** (Ustekinumab)	☐ 45mg/0.5ml ☐ 90mg/ml Disp.# _____	☐ 45mg subcutaneously initially and 4 weeks later, and then 45mg every 12 weeks thereafter (100kg)		
☐ **Xeljanz®** (Tofacitinib)	☐ 5mg Disp. #60	☐ 1 tab bid		
☐ **Xeljanz XR®**	☐ 11mg	☐ 11mg once daily		
☐ **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.