

Rheumatology Referral Form

Fax# _____

Patient Information

Patient Name: _____ DOB: _____ SS#: _____ Ship To: Home Clinic

Please Attach a Demographics Page & Copy of Insurance Card with this Prescription if Available:

1. **Diagnosis:** M06.9 Rheumatoid Arthritis L40.50 Psoriatic Arthritis Ankylosing Spondylitis Other: _____
2. **Drug Allergies:** _____
3. **Failed Medications:** Methotrexate Therapy Length: _____ Discontinuation Reason: _____
 _____ Therapy Length: _____ Discontinuation Reason: _____
4. **Negative TB Skin Test (PPD Test):** Yes No When: _____ (Please Attach)
5. **Forteo History:** T-Score: _____ Type: _____ Date: _____ Fracture History: Sites: _____ Dates: _____

Allergies: _____ Current Medications: _____

Enbrel ___ Sureclick _____ 50 mg Inject Enbrel _____ mg subcutaneously _____ x per week
___ Prefilled Syringe _____ 25 mg **Quantity: 28 day supply** Refills _____
___ Enbrel Mini

Xeljanz _____ Xeljanz 5mg twice daily as directed **Quantity: _____** Refills _____
_____ Xeljanz XR 11mg once daily as directed

Cimzia _____ Initial dose of 400 mg SC at weeks 0, 2, and 4 followed by:
_____ Maintenance dose of 400mg SC every 4 weeks **Quantity: 28 day supply**
_____ Maintenance dose of 200 mg SC every 2 weeks **Refills: _____**

Humira 40 mg / 0.8 ml _____ Inject 40mg SC every 2 weeks **Quantity: 28 day supply** Refills _____
___ Pen _____ Inject 40mg SC every week
___ Prefilled Syringe _____ Other _____

Simponi 50mg _____ 50mg Smartject Inject 50mg once every month **Quantity: # 30 day supply**
_____ 50 mg Prefilled Syringe **Refills _____**

Forteo 600 ug/2.4 ml Pen Inject 20ug SC once a day as directed **Quantity: _____** Refills _____

Orencia 125mg Syringe _____ Initial Loading Dosage: _____ **Quantity: 28 day supply** Refills _____
_____ Maintenance Dosage: Inject 125mg SQ once weekly

Stelara _____ Inject 45 mg SQ on day 1, again after 4 weeks, then every 12 weeks thereafter.
_____ Inject 90 mg SQ on day 1, again after 4 weeks, then every 12 weeks thereafter **Quantity: 28 day supply** Refills: _____

Otrexup Inject _____ SC once weekly as directed
___ 10mg / 0.4 ml _____ 15mg / 0.4 ml **Quantity: _____** Refills _____
___ 20mg / 0.4 ml _____ 25 mg / 0.4 ml

Otezla _____ Starter Pack _____ Take 1 tablet on day 1 then twice daily as directed **Quantity: 1 Pack**
_____ 30 mg Tablets _____ Take 1 tablet by mouth twice daily **Quantity: #60** Refills _____

Cosentyx 150mg _____ Loading Dose: Inject ___ 300mg or ___ 150mg SQ
_____ 150mg Pen _____ at week 0, 1, 2, 3, and 4 **Quantity: _____** Refills 0
_____ 150mg Prefilled Syringe _____ Maintenance: Inject ___300mg or ___ 150mg SQ
every 4 weeks **Quantity: _____** Refills _____

Rasuvo _____ mg _____ Inject _____ mg once weekly **Quantity # _____** Refills _____

Taltz 80mg/ml ___ AutoInjector _____ Load (Psoriatic Arthritis): Inject 160mg SQ on day 1 **Quantity: #2** Refills: 0
___ Prefilled Syringe _____ Maintenance: Inject 80mg SQ every 4 weeks **Quantity: #1** Refills: _____

Kevzara ___ Pre-filled Syringe ___ 150mg / 1.14 ml Inject Kevzara _____ mg SQ once every two weeks
___ Pre-filled Pen ___ 200mg / 1.14 ml **Quantity: 28 day supply** Refills: _____

Physician Prescription Orders

Physician Name: _____ NPI #: _____ Phone: _____ Fax: _____

Address: _____ Nurse: _____ Date: _____

Physician Signature: _____