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 ____ Inject 40mg SC every 2 weeks **Quantity: 28 day supply** **Refills ____**
__ Citrate Free (40mg / 0.4ml) ____ Inject 40mg SC every week
__ Regular (40mg / 0.8 ml) ____ 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: _____