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 ____**

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**
____ Maintenance Dosage: Inject 125mg SQ once weekly as directed **Refills _____**

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 Starter Pack**
__ 30 mg Tablets __ Take 1 tablet by mouth twice daily **Quantity: 60 Refills _____**

Cosentyx 150mg ___ Loading Dose: Inject __ 300mg or __ 150mg SQ at week 0, 1, 2, 3, and 4
___ 150mg Pen **Quantity: _____ Refills none**
___ 150mg Prefilled Syringe ___Maintenance: Inject __300mg or __ 150mg SQ every 4 weeks
Quantity: _____ Refills _____

Physician Prescription Orders

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

Address: _____ Nurse: _____ Date: _____

Physician Signature: _____