

Rheumatology Referral Form

Referral for Medication and Patient Management Program

Phone: 877 385 0535 Fax: 877 326 2856



V.06.05.17.A

Patient Demographics

Name: _____ M F
DOB: _____ SS#: _____
Phone: _____ 2nd Phone: _____
Address: _____
City: _____ State: _____ Zip: _____
Primary language, if other than English: _____
This is a: New Rx Refill

****Please fax a copy (front and back) of the patient's insurance card as well as any relevant clinical notes/documents****

Provider Information

Practice Name: _____
Address: _____
Phone: _____ Fax: _____
Prescriber: _____
NPI: _____ Office contact: _____
Training by: Prescriber's office Pharmacy to facilitate Not needed
Deliver first fill to: Prescriber's office Patient Other: _____

Clinical Information

| | | |
|---|---|---|
| Diagnosis: <input type="checkbox"/> Rheumatoid Arthritis (M06.9) <input type="checkbox"/> Psoriatic Arthritis (L40.59) <input type="checkbox"/> Ankylosing Spondylitis (M45.9) <input type="checkbox"/> Juvenile Idiopathic Arthritis (M08.0) <input type="checkbox"/> Other (ICD-10 code): _____ | Date of diagnosis: _____ Prior treatments & reason for discontinuation: _____ _____ _____ | Date of negative TB test: _____ <input type="checkbox"/> TB test pending, will fax results HBV negative or treated: <input type="checkbox"/> Yes <input type="checkbox"/> No Patient weight: _____ Height: _____ Allergies: _____ Other notes: _____ |
|---|---|---|

Prescription Information

| Medication | Directions | Quantity | Refills |
|---|---|---|--------------------------------|
| <input type="checkbox"/> Actemra 162mg (tocilizumab) | <input type="checkbox"/> Weight < 100kg: Inject 162mg SQ every OTHER week. <input type="checkbox"/> Weight ≥ 100kg or insufficient response: Inject 162mg SQ every week. | <input type="checkbox"/> 2 syringes <input type="checkbox"/> 4 syringes | _____ |
| <input type="checkbox"/> Cimzia 200mg (certolizumab) | <input type="checkbox"/> Induction: Inject 400mg SQ week 0, week 2, and week 4. Maintenance: <input type="checkbox"/> Inject 200mg SQ every OTHER week. <input type="checkbox"/> Inject 400mg SQ every 4 weeks. | 6 syringes <input type="checkbox"/> 2 syringes | Zero _____ |
| <input type="checkbox"/> Cosentyx 150mg (secukinumab) | Induction: <input type="checkbox"/> Inject 150mg SQ at weeks 0, 1, 2, and 3. <input type="checkbox"/> Inject 300mg SQ at weeks 0, 1, 2, and 3. Maintenance: <input type="checkbox"/> Beginning week 4, inject 150mg SQ once every 4 weeks. <input type="checkbox"/> Beginning week 4, inject 300mg SQ once every 4 weeks. <input type="checkbox"/> Other: _____ | 4 pens/syringes 8 pens/syringes <input type="checkbox"/> 1 pen/syringe <input type="checkbox"/> 2 pens/syringes <input type="checkbox"/> Other: _____ | Zero Zero _____ _____ |
| <input type="checkbox"/> Enbrel 50mg <input type="checkbox"/> Enbrel 25mg (etanercept) | <input type="checkbox"/> Inject 50mg SQ once weekly. <input type="checkbox"/> Other: _____ | <input type="checkbox"/> 4 pens/syringes <input type="checkbox"/> Other: _____ | _____ _____ |
| <input type="checkbox"/> Humira 40mg (adalimumab) | <input type="checkbox"/> Inject 40mg SQ every OTHER week. <input type="checkbox"/> Other: _____ | <input type="checkbox"/> 2 pens/syringes <input type="checkbox"/> Other: _____ | _____ _____ |
| <input type="checkbox"/> Kevzara (sarilumab) | <input type="checkbox"/> Inject 200mg SQ every OTHER week. <input type="checkbox"/> Dose modification: Inject 150mg SQ every OTHER week. | <input type="checkbox"/> 2 syringes <input type="checkbox"/> Other: _____ | _____ _____ |
| **REQUIRED:** Attach a copy of the patient's current ANC, platelet count, and LFTs. Labs should be reassessed 4 to 8 weeks after the start of therapy and every three months thereafter. Contact OptiMed for dosing recommendations based on laboratory results. | | | |
| <input type="checkbox"/> Orencia 125mg (abatacept) | <input type="checkbox"/> Inject 125mg SQ once weekly. | <input type="checkbox"/> 4 syringes | _____ |
| <input type="checkbox"/> Otezla 30mg (apremilast) | <input type="checkbox"/> Titration Starter Pack: Take as directed per package. <input type="checkbox"/> 14-day starter pack already given to patient. Date provided: _____ <input type="checkbox"/> Take one tablet PO BID. <input type="checkbox"/> Severe renal impairment: Take one tablet PO once daily. | 28-day starter pack N/A <input type="checkbox"/> 60 tablets <input type="checkbox"/> 30 tablets | Zero N/A _____ _____ |
| <input type="checkbox"/> Simponi 50mg (golimumab) | <input type="checkbox"/> Inject 50mg SQ once monthly. <input type="checkbox"/> Other: _____ | <input type="checkbox"/> 1 pen/syringe <input type="checkbox"/> Other: _____ | _____ _____ |
| <input type="checkbox"/> Stelara (ustekinumab) | Induction: Inject 1 syringe SQ on day 0. (Choose strength below) <input type="checkbox"/> Recommended initial dose: 45mg <input type="checkbox"/> Recommended dose for weight >100kg with moderate to severe PsA: 90mg Maintenance: Beginning on day 28, inject 1 syringe every 12 weeks. | <input type="checkbox"/> 1 syringe <input type="checkbox"/> 1 syringe | Zero _____ |
| <input type="checkbox"/> Xeljanz 5mg (tofacitinib) | <input type="checkbox"/> Take one tablet PO BID. <input type="checkbox"/> Moderate to severe renal impairment: Take one tablet PO once daily. | <input type="checkbox"/> 60 tablets <input type="checkbox"/> 30 tablets | _____ _____ |
| <input type="checkbox"/> Xeljanz XR 11mg (tofacitinib) | <input type="checkbox"/> Take one tablet PO once daily. (Not recommended for patients with moderate to severe renal or hepatic impairment) | <input type="checkbox"/> 30 tablets | _____ |

Please note, to increase adherence and patient acceptance all self-injectable medications will be dispensed as pen-type injectors unless unavailable or otherwise specified.

Provider Signature: _____ **Date:** _____

My signature for this prescription also authorizes OptiMed Pharmacy and its representatives to act as an agent of mine to initiate and execute the patient's insurance prior authorization process. Confidentiality statement: This message is intended only for the individual or institution to which it is addressed. This may contain information, which is confidential, privileged, and/or proprietary. This information may be exempt from disclosure under applicable laws including but not limited to HIPAA. If you are not the intended recipient, please note you are strictly prohibited from distributing, copying, or disseminating this information. If you received this information in error please notify the sender noted above and destroy all transmitted material.