# Rheumatology Referral Form

**Referral for Medication and Patient Management Program**

**Phone: 877 385 0535 Fax: 877 326 2856**

OptiMed SPECIALTY PHARMACY

V.11.15.17.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:**
☐Rheumatoid Arthritis (M06.9)
☐Psoriatic Arthritis (L40.59)
☐Ankylosing Spondylitis (M45.9)
☐Juvenille Idopathic Arthritis (M08.0)
☐Other (ICD-10 code): _____

**Date of diagnosis:** _____
**Prior treatments & reason for discontinuation:**
_____
_____
_____
_____

**Date of negative TB test:** _____
☐TB test pending, will fax results
**HBV negative or treated:** ☐Yes ☐No
Patient weight: _____ Height: _____
Allergies: _____
Other notes:_____

## Prescription Information

| Medication | Directions | Quantity | Refills |
|---|---|---|---|
| ☐Actemra 162mg (tocilizumab) | ☐Weight < 100kg: Inject 162mg SQ every OTHER week.<br>☐Weight ≥ 100kg or insufficient response: Inject 162mg SQ every week. | ☐2 syringes<br>☐4 syringes | _____ |
| ☐Cimzia 200mg (certolizumab) | ☐Induction: Inject 400mg SQ week 0, week 2, and week 4. | 6 syringes | Zero |
| | Maintenance: ☐Inject 200mg SQ every OTHER week.<br>☐Inject 400mg SQ every 4 weeks. | ☐2 syringes | _____ |
| ☐Cosentyx 150mg (secukinumab) | Induction: ☐Inject 150mg SQ at weeks 0, 1, 2, and 3.<br>☐Inject 300mg SQ at weeks 0, 1, 2, and 3. | 4 pens/syringes<br>8 pens/syringes | Zero<br>Zero |
| | Maintenance: ☐Beginning week 4, inject 150mg SQ once every 4 weeks.<br>☐Beginning week 4, inject 300mg SQ once every 4 weeks.<br>☐Other:_____ | ☐1 pen/syringe<br>☐2 pens/syringes<br>☐Other:_____ | _____ |
| ☐Enbrel 50mg<br>☐Enbrel 25mg (etanercept) | ☐Inject 50mg SQ once weekly.<br>☐Other:_____ | ☐4 pens/syringes<br>☐Other:_____ | _____ |
| ☐Humira 40mg (adalimumab) | ☐Inject 40mg SQ every OTHER week.<br>☐Other:_____ | ☐2 pens/syringes<br>☐Other:_____ | _____ |
| ☐Kevzara (sarilumab) | ☐Inject 200mg SQ every OTHER week.<br>☐Dose modification: Inject 150mg SQ every OTHER week. | ☐2 syringes<br>☐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. | | | |
| ☐Orencia 125mg (abatacept) | ☐Inject 125mg SQ once weekly. | ☐4 pens/syringes | _____ |
| ☐Otezla 30mg (apremilast) | ☐Titration Starter Pack: Take as directed per package.<br>☐14-day starter pack **already given to patient**. Date provided: _____ | 28-day starter pack<br>N/A | Zero<br>N/A |
| | ☐Take one tablet PO BID.<br>☐Severe renal impairment: Take one tablet PO once daily. | ☐60 tablets<br>☐30 tablets | _____ |
| ☐Simponi 50mg (golimumab) | ☐Inject 50mg SQ once monthly.<br>☐Other:_____ | ☐1 pen/syringe<br>☐Other:_____ | _____ |
| ☐Stelara (ustekinumab) | Induction: Inject 1 syringe SQ on day 0. (Choose strength below)<br>☐Recommended initial dose: 45mg<br>☐Recommended dose for weight >100kg with moderate to severe PsA: 90mg | ☐1 syringe | Zero |
| | ☐Maintenance: Beginning on day 28, inject 1 syringe every 12 weeks. | ☐1 syringe | _____ |
| ☐Xeljanz 5mg (tofacitinib) | ☐Take one tablet PO BID.<br>☐Moderate to severe renal impairment: Take one tablet PO once daily. | ☐60 tablets<br>☐30 tablets | _____ |
| ☐Xeljanz XR 11mg (tofacitinib) | ☐Take one tablet PO once daily.<br>(Not recommended for patients with moderate to severe renal or hepatic impairment) | ☐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.