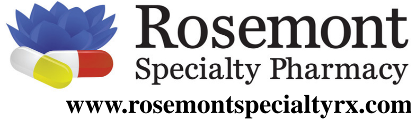
Rheumatoid Arthritis Prescription Referral Form

Phone: 1.877.592.7988
Fax: 1.800.787.0874



Date Medication Needed: ______________ **Ship To:** ○ Patient's Home ○ Prescriber's Office ○ Pick-up

1: Patient Information

Patient Name: ______________________ **Birthdate:** __________ **Sex:** ○ Male ○ Female **Height:** ______ **Weight:** ______ ○ lbs. ○ kg.

Soc. Sec. #: ______________ **Preferred Phone:** ______________ **Known Allergies:** ______________________

Address: ______________________________ **City:** ______________ **State:** ______ **Zip:** ______

Alternate Caregiver Name: ______________________ **Preferred Phone:** ______________________

Insurance Information: Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)

2: Prescriber Information

Provider Name: ______________________ **DEA#:** __________ **NPI#:** __________ **Tax ID#:** __________

Address: ______________________ **Phone:** ______________ **Fax:** ______________

City, State, Zip: ______________________ **Key Contact:** ______________ **Phone:** ______________

3: Diagnosis/Clinical Information | *Please FAX recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization*

Diagnosis:

☐ **Other:** ______________

Prior failed medications (medication and duration of treatment/reason for d/c):

☐ ______________________________

Is patient currently on RA therapy? ○ Yes ○ No

Medications: ______________________________

TB/PPD test given? ○ Yes ○ No

BMD/T-score: ______________ **Date:** ______________

Does patient have a latex allergy? ○ Yes ○ No

Is Patient at risk for osteoporotic fracture as evident by any of the following?

☐ History of osteoporotic fracture Site: ______________ Date: ______________

☐ Patient has tried and failed an oral bisphosphonate

☐ Patient has documented contraindication/is intolerant to oral bisphosphonate therapy (please submit a copy of DEXA w/prescription)

4: Prescription Information | *Xeljanz NOT to be used in combination with biologic DMARD's*

Medication	Dose/Strength	Sig	Qty.	Refills
☐ Benlysta®	☐ 200mg/ml autoinjector ☐ 200mg/ml PFS	☐ Inject 200mg SC once weekly in the abdomen or thigh **If transitioning from IV therapy with Benlysta to SC administration, administer the first SC dose 1 to 4 weeks after the last IV dose*	4-week supply	
☐ Enbrel®	☐ 50mg/ml SureClick™ Autoinjector ☐ 50mg/ml Prefilled Syringe ☐ 25mg/0.5ml Prefilled Syringe	☐ Inject 50mg SC ONCE a week ☐ Inject 25mg TWICE a week, 72 to 96 hours apart ☐ **Other:**	4-week supply	
☐ Forteo®	☐ 600mcg/2.4ml PFS	☐ Inject 20mcg SC, as directed, once daily	4-week supply	
☐ Humira® ☐ Injection training from My Humira *(patient must sign below)*	☐ 40mg/0.8ml Pen ☐ 40mg/0.8ml Prefilled Syringe	☐ Inject 40mg SC every OTHER week ☐ Inject 40mg SC ONCE a week	4-week supply	
☐ Kevzara®	☐ 150mg/1.14ml PFS ☐ 200mg/1.14ml PFS	☐ Inject 200mg SC once every 2 weeks ☐ **Other:**	4-week supply	
☐ Otezla®	*Please use Otezla-specific referral form available at **avella.com/forms***			
☐ Pen Needles	31 gauge 6mm		28 needles	
☐ Prolia®	☐ 60mg Prefilled Syringe	☐ Inject 60mg SC ONCE every 6 months		
☐ Simponi®	☐ 50mg/0.5ml Prefilled Syringe ☐ 50mg/0.5ml Autoinjector	☐ Inject 50mg ONCE a month	4-week supply	
☐				
☐				
☐				

Patient Support Programs: Please sign and date below to enroll in the pharmaceutical company assisted patient support program

Patient Signature: ______________________ Date: ______________

Prescriber Signature: Prescriber, please sign and date below

Dispense as written ______________ Date ______________ Substitution Permissable ______________ Date ______________

I authorize Rosemont Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressed and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient do not distribute or copy this fax. Please notify the sender immediately if you received this document in error and destroy this document immediately.

# of Prescriptions: ______________