Rheumatoid Arthritis
Prescription Referral Form
Phone: 1.877.592.7988
Fax: 1.800.787.0874
Escribe: # 5700174

Rosemont Specialty Pharmacy

www.rosemontspecialtyrx.com

URAC ACCREDITED Specialty Pharmacy Expires 01/01/2020

1. Patient Information

Patient Name:	SSN:	DOB:	
Address:	City:	State:	Zip:
Home Phone:	Cell Phone:	Email Address:	
Sex: ☐Male ☐Female	Height:	Weight: ☐ lbs. ☐ kg.	Known Allergies:

2. Insurance Information:

Please fax front and back copy of all Insurance cards (Prescription and Medical)

3. Diagnosis/Clinical Information:

Please fax recent clinical notes, labs, and tests with the prescription to expedite the Prior Authorization

Diagnosis:	ICD 10:

4. Prescription Information: For IV medications attach a copy of your prescription

Medication	Dose/Strength	Sig/Directions	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* ☐ **Other**	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 ☐ **Other**	4-week supply	
☐ **Humira***		☐ Inject 40mg SC every OTHER week ☐ Inject 40mg SC ONCE a week ☐ **Other**	4-week supply	
☐ **Humira*** **Citrate-Free**	☐ 40mg/0.4ml	☐ Inject 40mg SC every OTHER 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**	☐ 31gauge 6mm		28 needles	
☐ **Rinvoq***	☐ 15mg Tablet	☐ Take one tablet by mouth daily	30 day supply	
☐ **Simponi ***	☐ 50mg/0.5ml Prefilled Syringe ☐ 50mg/0.5ml Autoinjector	☐ Inject 50mg ONCE a month ☐ **Other**	4-week supply	
☐ **Other**				

Ship to: ☐ Patient ☐ Office ☐ Other

5. Physician Information:

Prescriber Name:	Prescriber NPI:	DEA#:	
Address:	City:	State:	Zip:
Primary Office Contact:	Fax Number:	Phone Number:	
Office Contact Email:			

Prescriber Signature: Prescriber, please sign and date below

*I authorize Rosemont Specialty Pharmacy and it's representatives to act as my authorized agent to secure coverage and initaite prior authorization process for my patient(s), and to sign any necessary forms on my behalf as authorized agents, including the recipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fullfill this prescription, I further authorize to forward this information and any related to coverage of the product to another pharmacy of patient's choice or in the patient's insurer's provider network.

☐ Dispense as written ☐ Substitution Permissible

Prescriber's Signature _____ Date _____

This prescription is valid only if transmitted by facsimile machine by a licensed prescriber.

RSP919