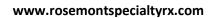
Rheumatoid Arthritis Prescription Referral Form Phone: 1.877.592.7988 Fax: 1.800.787.0874

Fax: 1.800.787.0874 Escribe: # 5700174







1. Patient Information													
Pa	tient Name:	SSN:				0	DOB:						
Address:				City:			State:		Zip:				
Home Phone: Cell Phone:						Email Addre	ess:						
Sex: ☐ Male ☐ Female Height: V			Weight:	□ lbs	. □ kg.	Known A	Allergies:						
2.	Insurance Information												
	Please fax front and back copy of all Insurance cards (Prescription and Medical)												
	Diagnosis/Clinical Info		()			,							
	ease fax recent clinical n		s with the i	orescription	to expedi	te the Pr	ior Authoriz	ation					
	agnosis:	ICD 10:											
4. Prescription Information: For IV medications attach a copy of your prescription													
	Medication	Dose/Strength		Sig/Direction	ons					Qty		Refills	
		☐ 200mg/ml autoinje	ctor				the abdomen o			4-week sı	upply		
	☐ 200mg/ml PFS			-	*If transitioning from IV therapy with Benlysta to SC administration,								
				□ Other	administer the first SC dose 1 to 4 weeks after the last IV dose								
	☐ Enbrel * ☐ 50mg/ml SureClick™ Autoinjector			_	☐ Inject 50mg SC ONCE a week					4-week supply			
		☐ Inject 25	mg TWICE a	week, 72 to	o 96 hours apa	rt							
	☐ 25mg/0.5ml Prefilled Syringe				☐ Other								
	☐ Forteo* ☐ 600mcg/2.4ml PFS			☐ Inject 20☐ ☐ Other	☐ Inject 20mcg SC, as directed, once daily ☐ Other					4-week si	upply		
	☐ Humira*			☐ Inject 40mg SC every OTHER week					4-week si	upply			
			-	☐ Inject 40mg SC ONCE a week									
	□ Humira * □ 40mg/0.4ml				☐ Other ☐ Inject 40mg SC every OTHER week					4-week si	unnly		
	Citrate-Free			inject 40						, weeks	аррту		
	☐ Kevzara * ☐ 150mg/1.14ml PFS			☐ Inject 20	☐ Inject 200mg SC once every 2 weeks					4-week sı	upply		
	☐ 200mg/1.14ml PFS			☐ Other:									
	Otezla* Please use Otezla-specific referral form			rm available at	m available at avella.com/forms								
	☐ Pen Needles ☐ 31gauge 6mm									28 needles			
	☐ Rinvoq* ☐ 15mg Tablet			□ Take one	☐ Take one tablet by mouth daily					30 day supply			
	☐ Simponi * ☐ 50mg/0.5ml Prefilled Syringe			☐ Inject 50mg ONCE a month						4-week supply			
		☐ 50mg/0.5ml Autoin	jector	☐ Other									
	□ Other												
ļ	Ship to: 🗆 Pation	ent 🗆 Office 🗀	Other	ı							L		
5	Physician Information												
	escriber Name:	•	Prescribe	Prescriber NPI:				DEA#:					
Address:			City				State:	DET III.	Zip:				
Primary Office Contact:				Fax Number:			Phone N	umber:					
	fice Contact Email:			1 47.114.111				1		<u> </u>			
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 initiatite 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													
Prescriber's Signature Date													
Confidentially Statement. This message is intended only for the individual or entity to which it is addressed, it may contain information which may be proprietary and confidential. It may also contain privileged, confidential information which is evenity from disclosure under applicable leave, including the Health insurance Portability and Accountability Accountability (ACC) (HIPAA). If you are not the intended recipient, glease note that, you are the their intended recipient, glease note that, you are the their intended recipient, glease note that, you are the their the intended recipient, glease note that, you are the their intended recipient, glease note that, you are not the intended recipient, glease note that, you are not the intended recipient, glease notify the sender immediately at the address and telephone number set forth herein and obtain instructions as to proper destruction of the transmitted material. Thank you. This prescription is valid only if transmitted by facsimile machine by a licensed prescriber.													
This prescription is valid only if transmitted by facsimile machine by a licensed prescriber. RSP919													