ameripharma SPECIALTY CARE

Rheumatology Referral Form

Phone#: 877-778-0318 Fax#: 877-778-0399

Patient Information

Patient Name: _____ DOB: _____ Sex: ☐ Male ☐ Female SSN: _____ Wt (kg/lbs): _____ Ht (cm/in): _____

Address: _____ Phone: _____ Alternate: _____

Caregiver Name: _____ Relation to Patient: _____ Phone: _____

Insurance Plan: _____ Plan ID: _____ BIN #: _____ PCN #: _____ GRP #: _____

Please fax a copy of the front and back of the insurance card(s).

Prescriber + Shipping Information

Prescriber Name: _____ DEA: _____ NPI: _____

Address: _____

Phone: _____ Alternate: _____ Fax: _____ Email: _____

If shipping to prescriber: ☐ First Fill ☐ Always ☐ Never

Clinical Information (Please fax all pertinent clinical and lab information)

Diagnosis: ☐ M06.9 (Rheumatoid Arthritis) ☐ M08.0 (Juvenille Idiopathic Arthritis) ☐ L40.59 (Psoriatic Arthritis) ☐ L40.54 (Psoriatic Juvenile Arthritis) ☐ M45.9 (Ankylosing Spondylitis) ☐ _____

Diagnosis Date: _____ TB Test: ☐ Yes ☐ No Negative Test Date: _____

Prior Therapy ☐ Yes ☐ No	Reason for Discontinuation of Therapy	Start Date	End Date

Comorbidities: _____

Concomitant Medications: _____

Allergies: ☐ NKDA ☐ Other: _____

Prescription	Directions, Quantity, Form			Refill
☐ **Actemra®** (tocilizumab)	☐ Inject 162 mg subq every week ☐ Inject 162 mg subq every other week ☐	☐ 4 x 162 mg/0.9mL ☐ 2 x 162 mg/0.9mL ☐	☐ PFS ☐ Vials	
☐ **Cimzia®** (certolizumab)	☐ Inject 400 mg subq at weeks 0, 2 and 4	☐ 6 x 200 mg/mL	☐ PFS ☐ Vials	0
	☐ Inject 200 mg subq every 2 weeks ☐ Inject 400 mg subq every 4 weeks	☐ 2 x 200 mg/mL	☐ PFS ☐ Vials	
☐ **Cosentyx®** (secukinumab)	☐ Inject 150 mg subq once weekly at weeks 0, 1, 2 and 3 ☐ Inject 300 mg subq once weekly at weeks 0, 1, 2 and 3	☐ 4 x 150 mg/mL ☐ 8 X 150 mg/mL	☐ Sensoready® Pen ☐ PFS	0
	☐ Inject 150 mg subq on day 29 and every 4 weeks thereafter ☐ Inject 300 mg subq on day 29 and every 4 weeks thereafter	☐ 1 x 150 mg/mL ☐ 2 x 150 mg/mL	☐ Sensoready® Pen ☐ PFS	
☐ **Enbrel®** (etanercept)	☐ Inject 50 mg subq every week ☐ Inject _____ mg (0.8 mg/kg x _____ kg) subq every week	☐ 4 x 50 mg/mL ☐ ____ x 25 mg/mL	☐ SureClick® Autoinjector ☐ PFS ☐ Vials	
☐ **Humira®** (adalimumab) *Adults & Pediatrics Age ≥ 2 years*	☐ Inject 10 mg subq every other week (10 to <15 kg) ☐ Inject 20 mg subq every other week (15 to <30 kg)	☐ 2 x 10 mg/0.2mL ☐ 2 x 20 mg/0.4mL	☐ PFS	
	☐ Inject 40 mg subq every other week (≥30 kg) ☐ Inject 40 mg subq once weekly	☐ 2 x 40 mg/0.8mL ☐ 4 x 40 mg/0.8mL	☐ Pens ☐ PFS	
☐ **Inflectra®** (infliximab) ☐ **Remicade®** (infliximab)	☐ Inject _____ mg (5mg/kg x _____ kg) IV at 0, 2, and 6 weeks, then every _____ weeks thereafter ☐ In conjunction with Methotrexate: Inject _____ mg (3mg/kg x _____ kg) IV at 0, 2, and 6 weeks, then every _____ weeks thereafter			

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Rheumatology Referral Form (continued)

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Prescription	Directions, Quantity, Form			Refill
☐ **Krystexxa®** (pegloticase injection) 8mg/mL	☐ Inject 8mg via intravenous infusion every 2 weeks			
☐ **Methotrexate®**	☐ Take _____ tablet(s) by mouth every week ☐ Inject _____ mL subq every 7 days at the same time each week		☐ 2.5mg Tablets ☐ 25mg/mL Injectable Solution	
☐ **Orencia®** (abatacept)	☐ Infuse _____ mg at week 0 **only** ☐ Infuse _____ mg at weeks 0 and 2	☐ _____ x 250 mg	☐ Vials	0
	(JIA <75 kg: 10 mg/kg; JIA ≥75 kg or RA:<60 kg: 500 mg, 60-100 kg: 750 mg; >100 kg: 1000 mg)			
	☐ Infuse _____ mg at week 4 and every 4 weeks thereafter	☐ _____ x 250 mg	☐ Vials	
	(JIA <75 kg: 10 mg/kg; JIA ≥75 kg or RA:<60 kg: 500 mg, 60-100 kg: 750 mg; >100 kg: 1000 mg)			
	☐ Inject 125 mg subq once weekly	☐ 4 x 125 mg/mL	☐ PFS ☐ ClickJect™	
☐ **Otezla®** (apremilast)	☐ Take as directed per package instructions	☐ 55 tablets	☐ 28-day starter pack	0
	☐ Take 30 mg twice daily by mouth ☐	☐ 60 x 30 mg tablets ☐		
☐ **Otrexup®** (methotrexate)	☐ Inject _____ mL subq every week	☐ 10mg Auto injector ☐ 15mg Auto injector ☐ 20mg Auto injector ☐ 25mg Auto injector	☐ 12.5mg Auto injector ☐ 17.5mg Auto injector ☐ 22.5mg Auto injector	
☐ **Rasuvo®** (methotrexate)	☐ Inject _____ mL subq every week	☐ 7.5mg Auto injector ☐ 12.5mg Auto injector ☐ 17.5mg Auto injector ☐ 22.5mg Auto injector ☐ 27.5mg Auto injector	☐ 10mg Auto injector ☐ 15mg Auto injector ☐ 20mg Auto injector ☐ 25mg Auto injector ☐ 30mg Auto injector	
☐ **Simponi®** (golimumab)	☐ Inject 50 mg subq once a month	☐ 1 x 50 mg/0.5mL	☐ SmartJect® Autoinjector ☐ PFS	
☐ **Simponi Aria®** (golimumab)	☐ Infuse _____ mg (2 mg/kg x _____ kg) over 30 minutes at weeks 0	☐ _____ x 50 mg/4ml	☐ Vials	0
	☐ Infuse _____ mg (2 mg/kg x _____ kg) over 3 minutes at week 4 and every 8 weeks thereafter	☐ _____ x 50 mg/4ml	☐ Vials	
☐ **Stelara®** (ustekinumab)	☐ Inject 45 mg subq on Day 1 (≤100 kg) ☐ Inject 90 mg subq on Day 1 (>100 kg)	☐ 1 x 45 mg/0.5mL ☐ 1 x 90 mg/mL	☐ PFS	0
	☐ Inject 45 mg subq on Day 29 and every 12 weeks thereafter (≤100 kg) ☐ Inject 90 mg subq on Day 29 and every 12 weeks thereafter (>100 kg)	☐ 1 x 45 mg/0.5mL ☐ 1 x 90 mg/mL	☐ PFS	
	Patient eligible for self administration: ☐ Yes ☐ No _____			
☐ **Xeljanz®** (tofacitinib)	☐ Take 5 mg by mouth twice daily ☐	☐ 60 x 5 mg tablets ☐		
☐ **Xeljanz®XR** (tofacitinib)	☐ Take 11 mg by mouth once daily	☐ 30 x 11 mg tablets		

Injection Training Provided by: ☐ Prescriber's Office ☐ Pharmacy ☐ Other: _____

Per state-specific law, prescriptions will be dispensed as generic, if applicable, unless notated otherwise: _____

Prescriber's Signature: _____ Date: _____

I authorize AmeriPharma and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above.
I understand that I can revoke this designation at any time by providing written notice to AmeriPharma.

Reset Form