

RHEUMATOID/PSORIATIC ARTHRITIS REFERRAL FORM



PATIENT INFORMATION

Last Name	First Name	DOB
Gender	Last 4 SSN	Primary Language
Address		
City	State	ZIP
Email		
Home Phone	Work Phone	Cell Phone
Primary Contact Method (check one)	<input type="checkbox"/> Cell Phone <input type="checkbox"/> Home Phone <input type="checkbox"/> Work Phone <input type="checkbox"/> Text <input type="checkbox"/> Email <input type="checkbox"/> Primary Caregiver <input type="checkbox"/> DO NOT CONTACT	
Primary Caregiver/Alt Contact Name (if applicable)		
Caregiver/Alt Contact Email	Caregiver/Alt Contact Phone	

PRESCRIBER INFORMATION

Name of Contact Sending Referral	Title
Preferred Contact Method (check one)	Referral Contact Email
<input type="checkbox"/> Email <input type="checkbox"/> Phone <input type="checkbox"/> Fax	
Office Phone	Office Fax
Practice / Facility Name	
Address	
City	State ZIP
Prescriber Name / Specialty	
Prescriber State License #	DEA #
NPI #	Medicaid UPIN #

INSURANCE INFORMATION

Insurance Provider	Plan ID #
BIN#:	PCN#:
Insured's Name	RX Group#:
	Relationship to Patient

Eligible for Medicare (check one)	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, list Medicare #
Prescription Card (check one)	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, list carrier

Please include a copy of the front and back of insurance card.

CLINICAL INFORMATION

Prescription Type	<input type="checkbox"/> Naïve/New Start <input type="checkbox"/> Therapy Restart <input type="checkbox"/> Existing Treatment	Therapy Start Date
Sample/Starter Product Provided?	If yes, Provide Qty	Date Sample Provided
<input type="checkbox"/> Yes <input type="checkbox"/> No		
If Self-injectable drug, is injection training coordination required by our pharmacy?	Allergies	
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> NKDA <input type="checkbox"/> Drug Allergies (please list)	
TB Skin Test Result	TB Result Date	

Patient Height (cm/in)	Patient Weight (kg/lbs)	Date Obtained
Other/Concomitant Medications		
Ship to Address	<input type="checkbox"/> Home <input type="checkbox"/> Prescriber's Office <input type="checkbox"/> Other (please list)	
ICD-10 Codes	<input type="checkbox"/> L40.50 Arthropathic Psoriasis	

We accept Escribe and fax prescriptions.

