RHEUMATOLOGY REFERRAL FORM A-G

Phone (888) 370.1724 Fax (877) 645.7514
10004 S. 152nd St, Suite A, Omaha NE 68138

Amber PHARMACY

Patient Information

PLEASE FAX INSURANCE CARD (FRONT AND BACK)

Last Name	First Name	DOB
Address		
City	State	ZIP
Phone	SSN	
Allergies		
Sex ☐ Male ☐ Female	Weight (kg)	Height (ft,in)
Insurance Plan	Plan ID #	

Prescriber Information

Practice/Facility Name		
Address		
City	State	ZIP
Prescriber Name		
Prescriber NPI		
Nurse/Key Contact	Phone/Pager	
Fax	Email	

Diagnosis/Clinical Information

PLEASE FAX CLINICAL AND LAB INFORMATION

Primary Diagnosis: ☐ M06.9 Rheumatoid Arthritis ☐ M08.00 Juvenile Rheumatoid Arthritis ☐ L40.59 Psoriatic Arthritis
☐ L40.54 Psoriatic Juvenile Arthritis ☐ M45.9 Ankylosing Spondylitis ☐ Other:_____

Date of diagnosis/years with the disease: _____

Prior Therapy: ☐ No ☐ Yes (provide details): _____

Concurrent Therapy: ☐ No ☐ Yes (provide details):_____

TB Test: ☐ No ☐ Yes (date): _____ Results: _____

Additional Information

Today's Date	Delivery Date	Deliver to: ☐ Home ☐ Prescriber	Special Instructions

Prescription Information

MEDICATION	DOSE/STRENGTH	DIRECTIONS FOR USE	QTY	REFILLS
☐ **Actemra®** IV Administration *Current Weight:* _____kg	☐ 80 mg Vial ☐ 200 mg Vial ☐ 400 mg Vial	☐ 4 mg/kg IV once every 4 weeks ☐ Other: _____	QS	
☐ **Actemra®** SC Administration *Current Weight:* _____kg	162 mg (0.9 ml) PFS	☐ 162 mg SC every other week (<100 kg) ☐ 162 mg SC once a week (>/=100 kg)	2 4	
☐ **Cimzia®**	**Starter Dose:** ☐ 200 mg/ml PFS ☐ 200 mg Lyophilized powder vial	☐ Initial dose of 400 mg SC at weeks 0, 2, and 4	6	0
	Maintenance Dose: ☐ 200 mg/ml PFS ☐ 200 mg Lyophilized powder vial	☐ 400 mg SC every 4 weeks ☐ 200 mg SC every 2 weeks	4-week supply	
☐ **Cosentyx®**	☐ 150 mg/ml PFS ☐ 150 mg/ml Sensoready Pen	**No Loading Dose:** ☐ 150 mg SC every 4 weeks ☐ 300 mg SC every 4 weeks	4-week supply	
		Loading Dose: ☐ 150 mg SC at weeks 0, 1, 2, and 3 ☐ 300 mg SC at weeks 0, 1, 2, and 3	4 8	0 0
		Maintenance Dose: ☐ 150 mg SC at week 4, then 150 mg SC every 4 weeks thereafter ☐ 300 mg SC at week 4, then 300 mg SC every 4 weeks thereafter	1 2	
☐ **Enbrel®** Adult Dosing	☐ 50 mg/ml Sureclick™ Autoinjector ☐ 50 mg/ml PFS ☐ Enbrel® Mini 50 mg/ml ☐ 25 mg Vial (inj supplies included) ☐ 25 mg /0.5 ml PFS	☐ Inject 50 mg SC once a week ☐ Other: _____	4-week supply	
☐ **Enbrel®** Pediatric Dosing Children ≥ 2 years old and adolescents Current weight: _____kg	☐ 25 mg/0.5 ml PFS ☐ 25 mg Vial (inj supplies included) ☐ 50 mg/ml PFS ☐ Enbrel® Mini ☐ 50 mg /ml Sureclick™ Autoinjector	☐ <63 kg: Inject 0.8 mg/kg (_____mg) SC once weekly *(max 50 mg per dose)* ☐ ≥63 kg: Inject 50 mg SC once weekly (Children must weigh at least 138 pounds)	4-week supply	

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary," or your state-specific required language to prohibit substitution:

PRESCRIBER MUST MANUALLY SIGN - STAMP SIGNATURE, SIGNATURE BY OTHER PERSONNEL AND COMPUTER-GENERATED SIGNATURES WILL NOT BE ACCEPTED

PRODUCT SUBSTITUTION PERMITTED/Brand exchange permitted (date)

DISPENSE AS WRITTEN/Do Not Substitute (date)

RHEUMATOLOGY REFERRAL FORM H-O

Phone (888) 370.1724 Fax (877) 645.7514
10004 S. 152nd St, Suite A, Omaha NE 68138

Amber PHARMACY

Patient Information

PLEASE FAX INSURANCE CARD (FRONT AND BACK)

Last Name	First Name	DOB
Address		
City	State	ZIP
Phone	SSN	
Allergies		
Sex ☐ Male ☐ Female	Weight (kg)	Height (ft,in)
Insurance Plan	Plan ID #	

Prescriber Information

Practice/Facility Name		
Address		
City	State	ZIP
Prescriber Name		
Prescriber NPI		
Nurse/Key Contact	Phone/Pager	
Fax	Email	

Diagnosis/Clinical Information

Primary Diagnosis: ☐ M06.9 Rheumatoid Arthritis ☐ M08.00 Juvenile Rheumatoid Arthritis ☐ L40.59 Psoriatic Arthritis
☐ L40.54 Psoriatic Juvenile Arthritis ☐ M45.9 Ankylosing Spondylitis ☐ Other:_____

Date of diagnosis/years with the disease: _____

Prior Therapy: ☐ No ☐ Yes (provide details): _____

Concurrent Therapy: ☐ No ☐ Yes (provide details):_____

TB Test: ☐ No ☐ Yes (date): _____ Results: _____

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Prescription Information

MEDICATION	DOSE/STRENGTH	DIRECTIONS FOR USE	QTY	REFILLS
☐ **Humira®**	**Maintenance Dose:** ❑ 40mg/0.8mL Pen ❑ 40mg/0.8mL PFS ❑ 40mg/0.4mL Pen (Citrate-free) ❑ 40mg/0.4mL PFS (Citrate-free)	❑ 40mg SC injection EVERY OTHER week ❑ Other:_____	#2 ____ #__ ____	_____
☐ **Kevzara®**	☐ 200 mg/1.14 ml PFS ☐ 150 mg/1.14 ml PFS	☐ 200 mg SC once every 2 weeks ☐ 150 mg SC once every 2 weeks	4-week supply	_____
☐ **Methotrexate®**	☐ 2.5 mg tablet	Take_____ mg (_____ tablets) by mouth once weekly on the same day each week	4-week supply	_____
	☐ 25 mg/mL (2 mL vial) Inj	Inject _____ mg SQ once weekly on the same day each week	4-week supply	_____
☐ **Orencia®** *IV Administration* *Current Weight:* _____ kg	☐ Orencia 250 mg vial ☐ **Adult** <60 kg = 500 mg 60-100 kg = 750 mg >100 kg = 1,000 mg ☐ **Pediatric (6-17 years)** <75 kg = 10 mg/kg 75-100 kg = 750 mg >100 kg = 1,000 mg (max dose)	**Initial Dose:** ☐ Infuse_____ mg IV at week 0 only, then transition to SC ☐ Infuse_____ mg IV at week 0 and 2 **Maintenance Dose:** ☐ Infuse_____mg IV at week 4 and then every 4 weeks thereafter	_____ 4-week supply	0 _____
☐ **Orencia®** *SC Administration* *Current Weight:* _____ kg	☐ Orencia 125 mg/ml PFS ☐ Orencia 125 mg/ml ClickJect™ ☐ Orencia 87.5 mg/0.7 ml PFS ☐ Orencia 50 mg/0.4 ml PFS	☐ **Adult Dose:** 125 mg SC once weekly ☐ **Pediatric Dose: (> 2 years)** 10 – <25 kg 50 mg SC once weekly ≥25 kg – <50 kg 87.5 mg SC once weekly >50 kg 125 mg SC once weekly	4-week supply	_____
☐ **Otrexup®**	Auto-injector: ☐ 10 mg/0.4 ml ☐ 20 mg/0.4 ml ☐ 12.5 mg/0.4 ml ☐ 22.5 mg/0.4 ml ☐ 15 mg/0.4 ml ☐ 25 mg/0.4 ml ☐ 17.5 mg/0.4 ml	Inject _____ mg SQ once weekly on the same day each week	4	_____

For Otezla, please see "Rheumatology O-R" form.

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RHEUMATOLOGY REFERRAL FORM O-R

Phone (888) 370.1724 Fax (877) 645.7514
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Amber PHARMACY

Patient Information

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Last Name	First Name	DOB
Address		
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Allergies		
Sex ☐ Male ☐ Female	Weight (kg)	Height (ft,in)
Insurance Plan	Plan ID #	

Prescriber Information

Practice/Facility Name		
Address		
City	State	ZIP
Prescriber Name		
Prescriber NPI		
Nurse/Key Contact	Phone/Pager	
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Diagnosis/Clinical Information

PLEASE FAX CLINICAL AND LAB INFORMATION

Primary Diagnosis: ☐ M06.9 Rheumatoid Arthritis ☐ M08.00 Juvenile Rheumatoid Arthritis ☐ L40.59 Psoriatic Arthritis
☐ L40.54 Psoriatic Juvenile Arthritis ☐ M45.9 Ankylosing Spondylitis ☐ Other:_____

Date of diagnosis/years with the disease: _____

Prior Therapy: ☐ No ☐ Yes (provide details): _____

Concurrent Therapy: ☐ No ☐ Yes (provide details):_____

TB Test: ☐ No ☐ Yes (date): _____ Results: _____

Additional Information

Today's Date	Delivery Date	Deliver to:	Special Instructions
		☐ Home ☐ Prescriber	

Prescription Information

MEDICATION	DOSE/STRENGTH	DIRECTIONS FOR USE	QTY	Refills
☐ **Otezla®** Adult Dosing	☐ **Starter Pack** (Titration) (55 tablets)	☐ Take as directed per package or prescriber instructions	28 day starter pack	0
	☐ **Maintence Rx** 30 mg (Otezla tablets)	☐ Take one tablet by mouth twice daily	60	
		☐ Take one tablet by mouth once daily	30	
	☐ **Bridge Rx** 30 mg (Otezla tablets)	☐ Take one tablet by mouth twice daily	28/14 day supply	12 refills
		☐ Take one tablet by mouth once daily	28/28 day supply	6 refills
☐ **Rasuvo®**	Auto-injector: ☐ 7.5 mg/0.15 ml ☐ 20 mg/0.4 ml ☐ 10 mg/0.2 ml ☐ 22.5 mg/0.45 ml ☐ 12.5 mg/0.25 ml ☐ 25 mg/0.5 ml ☐ 15 mg/0.3 ml ☐ 30 mg/0.6 ml ☐ 17.5 mg/0.35 ml	Inject_____ mg SQ once weekly on the same day each week	4	
☐ **Remicade®** *Current Weight:* _____kg Biosimilars: ☐ **Inflectra** ☐ **Renflexis**	☐ 100 mg Vial	**Initial Dose:** ☐ 3 mg/kg (_____mg) IV at week 0 and 2 ☐ 5 mg/kg (_____mg) IV at week 0 and 2 ☐ Other:	QS QS	0 0
		Maintenance Dose: ☐ Starting at week 6, infuse 3 mg/kg (_____mg) once every 8 weeks ☐ Starting at week 6, infuse 5 mg/kg (_____mg) once every 8 weeks ☐ Starting at week 6, infuse 5 mg/kg (_____mg) once every 8 weeks ☐ Other:	QS QS QS	
☐ **Rituxan®**	☐ 500mg/50 ml vial	☐ Infuse 1000mg IV at weeks 0 and 2; then repeat the course every ☐ 24 weeks ☐ Other: weeks (recommended no sooner than every 16 weeks)	4	

***For Orencia and Otrexup, please see "Rheumatology H-O" form.**

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PRODUCT SUBSTITUTION PERMITTED/Brand exchange permitted (date) _____

DISPENSE AS WRITTEN/Do Not Substitute (date) _____

RHEUMATOLOGY REFERRAL FORM

S-Z

Phone 888.370.1724 Fax 877.645.7514
10004 S. 152nd St, Suite A, Omaha NE 68138

Amber PHARMACY

Patient Information

PLEASE FAX INSURANCE CARD (FRONT AND BACK)

Last Name	First Name	DOB
Address		
City	State	ZIP
Phone	SSN	
Allergies		
Sex ☐ Male ☐ Female	Weight (kg)	Height (ft,in)
Insurance Plan	Plan ID #	

Prescriber Information

Practice/Facility Name		
Address		
City	State	ZIP
Prescriber Name		
Prescriber NPI		
Nurse/Key Contact	Phone/Pager	
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Diagnosis/Clinical Information

PLEASE FAX CLINICAL AND LAB INFORMATION

Primary Diagnosis: ☐ M06.9 Rheumatoid Arthritis ☐ M08.00 Juvenile Rheumatoid Arthritis ☐ L40.59 Psoriatic Arthritis
☐ L40.54 Psoriatic Juvenile Arthritis ☐ M45.9 Ankylosing Spondylitis ☐ Other:_____

Date of diagnosis/years with the disease: _____

Prior Therapy: ☐ No ☐ Yes (provide details): _____

Concurrent Therapy: ☐ No ☐ Yes (provide details):_____

TB Test: ☐ No ☐ Yes (date): _____ Results: _____

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Prescription Information

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☐ **Simponi®**	☐ 50 mg/0.5 ml SmartJect® Pen ☐ 50 mg/0.5 ml PFS	☐ Inject 50mg SC once a month	1	
☐ **Simponi Aria®** *Current Weight:* _____ kg	☐ 50 mg/4 ml Vial	**Induction Dose:** ☐ Infuse 2 mg/kg (_____mg) over 30 minutes at week 0	QS	
		Maintenance Dose: ☐ Infuse 2 mg/kg (_____mg) over 30 minutes at week 4 and then every 8 weeks thereafter	QS	0
☐ **Stelara** *Current Weight:* _____ kg (recommended dose for coexistent PsA & PsO in patients>100kg = 90mg)	☐ 45 mg/0.5 ml PFS ☐ 90 mg/1 ml PFS	**Induction Dose:** ☐ Inject 45 mg SC on day 1 ☐ Inject 90 mg SC on day 1	1	0
		Maintenance Dose: ☐ Inject 45 mg SC on day 29 and every 12 weeks thereafter ☐ Inject 90 mg SC on day 29 and every 12 weeks thereafter	1	
☐ **Taltz®**	☐ 80 mg/ml PFS ☐ 80 mg/ml Pen	**Induction Dose (Psoriatic Arthritis):** ☐ Inject 160mg (2x80mg) SC once at week 0	2x80mg	0
		Induction Dose (Psoriasis or Psoriatic Arthritis with coexisting Psoriasis): ☐ Inject 160mg (2x80mg) SC at week 0, followed by 80mg SC at week 2 ☐ Inject 80mg SC at week 4 and every 2 weeks thereafter through week 10 ☐ Inject 80mg SC at week 12 and every 4 weeks thereafter	3x80mg 4x80mg 1x80mg	0 0 0
		☐ **Maintenance Dose (Psoriasis/Psoriatic Arthritis/Psoriatic Arthritis with coexisting Psoriasis):** Inject 80mg SC every 4 weeks	1x80mg	
☐ **Xatmep®** kg (dosing for pJIA)	☐ 2.5 mg/ml oral solution	☐ Take _____mg one time weekly	4 week supply	
☐ **Xeljanz®**	☐ 5 mg tablet	☐ Take one tablet by mouth once daily	30	
		☐ Take one tablet by mouth twice daily	60	
☐ **Xeljanz XR®**	☐ 11 mg XR tablet	☐ Take one tablet by mouth once daily	30	

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