

# RHEUMATOLOGY REFERRAL FORM

# P-Z

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



Patient Information			PLEASE FAX INSURANCE CARD (FRONT AND BACK)			Prescriber Information			
Last Name		First Name		DOB		Practice/Facility Name			
Address						Address			
City		State		ZIP		City		State	ZIP
Phone			SSN			Prescriber Name			
Allergies						Prescriber NPI			
Sex	Male	Female	Weight (kg)		Height (ft,in)	Nurse/Key Contact		Phone/Pager	
Insurance Plan			Plan ID #			Fax		Email	

Diagnosis/Clinical Information		PLEASE FAX CLINICAL AND LAB INFORMATION	
Primary Diagnosis: M06.9 Rheumatoid Arthritis <input type="checkbox"/> M08.00 Juvenile Rheumatoid Arthritis <input type="checkbox"/> L40.59 Psoriatic Arthritis <input type="checkbox"/> <input type="checkbox"/> L40.54 Psoriatic Juvenile Arthritis <input type="checkbox"/> M45.9 Ankylosing Spondylitis <input type="checkbox"/> Other: _____			
Date of diagnosis/years with the disease: _____			
Prior Therapy: <input type="checkbox"/> No <input type="checkbox"/> Yes (provide details): _____			
Concurrent Therapy: <input type="checkbox"/> No <input type="checkbox"/> Yes (provide details): _____			
TB Test: <input type="checkbox"/> No <input type="checkbox"/> Yes (date): _____ Results: _____			

Additional Information			
Today's Date	Delivery Date	Deliver to:	Special Instructions
		Home Physician	

Prescription Information				
MEDICATION	DOSE/STRENGTH	DIRECTIONS FOR USE	QTY	Refills
<b>Remicade®</b> Current Weight: _____ kg Biosimilars: <b>Inflectra</b> <b>Renflexis</b>	100 mg Vial	<b>Initial Dose:</b> 3 mg/kg (____mg) IV at week 0 and 2 5 mg/kg (____mg) IV at week 0 and 2	QS	0
		<b>Maintenance Dose:</b> Starting at week 6, infuse 3 mg/kg (____mg) once every 8 week Starting at week 6, infuse 5 mg/kg (____mg) once every 8 week Starting at week 6, infuse 5 mg/kg (____mg) once every 8 week	QS	0
<b>Simponi®</b>	50 mg/0.5 ml Autoinjector 50 mg/0.5 ml PFS	Inject 50mg SC once a month	1	
<b>Simponi Aria®</b> Current Weight: _____ kg	50 mg/4 ml Vial	<b>Initial Dose:</b> Infuse 2 mg/kg (____mg) over 30 minutes at week 0	QS	
		<b>Maintenance Dose:</b> Infuse 2 mg/kg (____mg) over 30 minutes at week 4 and then every 8 weeks thereafter	QS	0
<b>Stelara®</b> Current Weight: _____ kg <small>(recommended dose for coexistent PsA &amp; PsO in patients &gt;100kg = 90mg)</small>	45 mg/0.5 ml PFS 90 mg/1 ml PFS	<b>Initial Dose:</b> Inject 45 mg SC on day 1 Inject 90 mg SC on day 1	1	
		<b>Maintenance Dose:</b> 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	0
<b>Xeljanz®</b>	5 mg tablet	Take one tablet my mouth once daily	30	
		Take one tablet my mouth twice daily	60	
<b>Xeljanz XR®</b>	11 mg XR tablet	Take one tablet my mouth once daily	30	

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)

I authorize Amber Pharmacy and its representatives to act as my agent in order to initiate and execute the insurance prior authorization process and, in doing so, to release clinical information via phone to the appropriate third party payer.

Confidentiality 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 exempt from disclosure under applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA). If you are not the intended recipient, please note that you are strictly prohibited from disseminating or distributing this information (other than to the intended recipient) or copying this information. If you received this communication in error, please 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.