RHEUMATOLOGY REFERRAL FORM

P-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	
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:	Special Instructions
		☐ Home ☐ Physician	

Prescription Information

MEDICATION	DOSE/STRENGTH	DIRECTIONS FOR USE	QTY	Refills
☐ **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	QS QS	0 0
		Maintenance Dose: ☐ 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 QS QS	
☐ **Simponi®**	☐ 50 mg/0.5 ml Autoinjector ☐ 50 mg/0.5 ml PFS	☐ Inject 50mg SC once a month	1	
☐ **Simponi Aria®** *Current Weight:* _____kg	☐ 50 mg/4 ml Vial	**Initial 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	**Initial Dose:** ☐ Inject 45 mg SC on day 1 ☐ Inject 90 mg SC on day 1	1	
		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	0
☐ **Xeljanz®**	☐ 5 mg tablet	☐ Take one tablet my mouth once daily	30	
		☐ Take one tablet my mouth twice daily	60	
☐ **Xeljanz XR®**	☐ 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.