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)

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)

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