Rheumatology Referral Form

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

Patient Information

Last Name	First Name	Home Phone	Work/Mobile Phone	
Home Address		City	State	ZIP
Shipping Address (if different from above)		City	State	ZIP

Social Security Number	Gender (M/F)	Weight	Date of Birth	Allergies

Emergency Contact	Phone	Primary Caregiver	Phone

Healthcare Provider Information: *Indicates Required Field

Practice/Facility Name	**Physician First and Last Name***	**Phone***	Fax

Address*	**City***	**State***	**ZIP***

Physician NPI#*	Physician UPIN#	Physician DEA#	Physician State License #

Nurse/Key Contact	Phone or Pager Number	Email

Insurance Information: *PLEASE FAX A COPY OF INSURANCE CARD (FRONT AND BACK)*

Diagnosis: ❑ 714.0 Rheumatoid Arthritis ❑ 696.0 Psoriatic Arthritis ❑ 720.0 Ankylosing Spondylitis
❑ Other: Date of Diagnosis or Years with Disease:

Other clinical information:

Hepatitis B test result: ❑ Positive ❑ Negative **TB test result:** ❑ Positive ❑ Negative **Does patient have a latex allergy?** ❑ Yes ❑ No **Is patient also taking Methotrexate?** ❑ Yes ❑ No

Current/Prior Therapies: ____________________

Delivery Information

Today's Date	Delivery Date	Deliver to: ❑ Home ❑ Physician	Amber Pharmacy to initiate arrangement of injection training to take place at patient's home ❑ Yes ❑ No	Special Instructions

Medication	Dose/Strength	Sig	Qty.	Refills
❑ Actemra®	❑ 162mg (0.9ml) Prefilled syringe	❑ 162mg SC every OTHER week ❑ 162mg SC ONCE a week ❑ Alternate Dosing: ____________	2 4 ____	____
❑ Cimzia®	**Starter Dose:** ❑ 200mg/ml Prefilled syringe ❑ 200mg Lyophilized powder vial	Initial dose of 400mg SC at weeks 0, 2, and 4	1 kit 3 kits	0
	Maintenance Dose: ❑ 200mg/ml Prefilled syringe ❑ 200mg Lyophilized powder vial	❑ 400mg SC every 4 weeks ❑ 200mg SC every 2 weeks	4-week supply	____
❑ Enbrel®	❑ 50mg/ml Sureclick™ Autoinjector ❑ 50mg/ml Prefilled syringes ❑ 25mg Vial (inj supplies included) ❑ 25mg /0.5ml Prefilled syringe	❑ Inject 50mg SQ ONCE a week ❑ Inject 25mg SQ TWICE a week ❑ Alternate Dosing: ____________	4-week supply	____
❑ Humira®	❑ 40mg/0.8ml Pen ❑ 40mg/0.8ml Prefilled syringe	❑ Inject 40mg SC every OTHER week ❑ Inject 40mg SC ONCE a week ❑ Alternate Dosing: ____________	4-week supply	
❑ Orencia®	❑ 250mg Vial (IV use only)	❑ Loading Dose: 10mg/kg IV x 1 dose, then 125mg SC weekly, start within 24 hours of IV dose	1 dose	0
	❑ 125mg/ml Prefilled syringe	❑ 125mg SC ONCE a week	4-week supply	____
❑ Simponi®	❑ 50mg/0.5ml Autoinjector ❑ 50mg/0.5ml Prefilled syringe	❑ Inject 1 single-use Autoinjector SC ONCE monthly ❑ Inject 1 single-use Prefilled syringe SC ONCE monthly	1 (one)	____
❑ Xeljanz®	❑ 5mg tablet	❑ 5mg PO BID ❑ Alternate Dosing: ____________	____	____
❑				

*****When sending a referral please include all clinical information relevant to performing a prior authorization and copies of patient's insurance cards*****

Physician Signature:____________________ ❑ **DAW** (Dispense as Written) **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.

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