

**RHEUMATOLOGY
REFERRAL FORM**

A-G

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: <input type="checkbox"/> M06.9 Rheumatoid Arthritis <input type="checkbox"/> M08.00 Juvenile Rheumatoid Arthritis <input type="checkbox"/> L40.59 Psoriatic Arthritis <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: Home Prescriber		Special Instructions

Prescription Information				
MEDICATION	DOSE/STRENGTH	DIRECTIONS FOR USE	QTY	REFILLS
Actemra® IV Administration Current Weight: _____kg	80 mg Vial	4 mg/kg IV once every 4 weeks	QS	
	200 mg Vial 400 mg Vial	Other: _____		
Actemra® SC Administration Current Weight: _____kg	162 mg (0.9 ml) PFS	162 mg SC every other week (<100 kg)	2	
		162 mg SC once a week (>=100 kg)	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)

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Sex	Male	Female	Weight (kg)		Height (ft,in)	Nurse/Key Contact		Phone/Pager	
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Humira®	Maintenance Dose: <input type="checkbox"/> 40mg/0.8mL Pen <input type="checkbox"/> 40mg/0.8mL PFS <input type="checkbox"/> 40mg/0.4mL Pen (Citrate-free) <input type="checkbox"/> 40mg/0.4mL PFS (Citrate-free)	<input type="checkbox"/> 40mg SC injection EVERY OTHER week <input type="checkbox"/> 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® <i>IV Administration</i> <i>Current Weight:</i> _____ kg	Orencia 250 mg vial	Initial Dose: Infuse _____ mg IV at week 0 only, then transition to SC Infuse _____ mg IV at week 0 and 2		0
	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)	Maintenance Dose: Infuse _____ mg IV at week 4 and then every 4 weeks thereafter	4-week supply	
Orencia® <i>SC Administration</i> <i>Current Weight:</i> _____ kg	Orencia 125 mg/ml PFS	Adult Dose: 125 mg SC once weekly	4-week supply	
	Orencia 125 mg/ml ClickJect™ Orencia 87.5 mg/0.7 ml PFS Orencia 50 mg/0.4 ml PFS	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		
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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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
	Maintenance 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 10 mg/0.2 ml 12.5 mg/0.25 ml 15 mg/0.3 ml 17.5 mg/0.35 ml 20 mg/0.4 ml 22.5 mg/0.45 ml 25 mg/0.5 ml 30 mg/0.6 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	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 <input type="checkbox"/> Other:	QS	0
			QS	

*For Orencia and Otrexup, please see "Rheumatology H-0" form.

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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 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 <small>(recommended dose for coexistent PSA & PsO in patients >100kg = 90mg)</small>	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 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 1	0
Taltz®	80 mg/ml PFS 80 mg/ml Pen	Induction Dose (Psoriatic Arthritis): Inject 160mg (2x80mg) SC once at week 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 Maintenance Dose (Psoriasis/Psoriatic Arthritis/Psoriatic Arthritis with coexisting Psoriasis): Inject 80mg SC every 4 weeks	2x80mg	0 0 0 0
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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