Add Logo

RHEUMATOLOGY REFERRAL FORM

EHR: select (Add company name)
Fax: (000) 000-0000
Phone: (000) 000-0000

Patient Name:	SSN:		DOB:
Address:	City:	State:	Zip:
Home Phone:	Cell:	Email:	Gender: ◉ Male ◉ Female

CLINICAL INFORMATION

Diagnosis: ☐ Rheumatoid Arthritis ☐ Psoriatic Arthritis ☐ Ankylosing Spondylitis ☐ Juvenile Rheumatoid Arthritis ☐ Iridocyclitis (Uveitis) ☐ Other:_____

Allergies: | Weight: | Height:

TB Test Result: | Date: | HepB Test Result: | Date:

Prior Failed Meds: ☐ Actemra® ☐ Cosentyx® ☐ Cimzia® ☐ Enbrel® ☐ Humira® ☐ Kevzara® ☐ Orencia® ☐ Otezla® ☐ Other: _____

Prior Methotrexate/Oral Systemic Medications: ☐ Yes ☐ No ☐ Contraindicated

INSURANCE INFORMATON (or attach copy of the cards)

Primary Insurance:	Policy Holder:	Relationship:	Policy #:	Group #:
Secondary Insurance:	Policy Holder:	Relationship:	Policy #:	Group #:

PRESCRIPTION INFORMATION (for IV medication attach a copy of the prescription)

ACTEMRA® *(tocilizumab)*
Maintenance: ☐ 80 mg/ 4 ml ☐ 200 mg/ 10 ml
☐ 400 mg/ 20 ml ☐ 162 mg/ 0.9 ml prefilled syringe
☐ 162 mg/ 0.9 ml Pen
☐ **Infuse** (☐ 4 mg/ kg ☐ 8 mg/ kg) IV every 4 weeks
☐ **Inject** 162 mg SubQ (☐ QOW ☐ QW)
Qty: **Refills:**

AMJEVITA™ *(adalimumab-atto)* ☐ SureClick 40 mg/0.8 mL
☐ Prefilled Syringe 20 mg/0.4 mL
☐ Prefilled Syringe 40 mg/0.8 mL
☐ **Inject** 40 mg every other week and __ mg every other week
Qty: **Refills:**

CIMZIA® *(certolizumab pegol)* Prefilled Syringe
☐ **Induction:** Inject 400 mg (2 x 200 mg/ ml) SubQ at weeks 0, 2, and 4
Qty: 6 **Refills:**
Maintenance:
☐ 400 mg (2 x 200 mg) SubQ every 4 wks
☐ 400 mg (2 x 200 mg) SubQ every 2 wks
☐ 200 mg SubQ every 2 wks
Qty: **Refills:**

COSENTYX™ *(secukinumab)*
☐ 150 mg Pen
☐ 75 mg Prefilled Syringe ☐ 150 mg Prefilled Syringe
☐ Inject 300 mg (2 x 150 mg/ml) SubQ week 0, 1, 2, 3, 4
Qty: 10 **Refills:** 0
☐ Inject 150 mg SubQ week 0,1,2,3,4
Qty: 5 **Refills:**
Maintenance:
☐ Inject 300 mg SubQ every 4 weeks
☐ Inject 150 mg SubQ every 4 weeks
Qty: 28 days **Refills:**
☐ **Bridge***

ENBREL® *(etanercept)*
☐ Mini Cartridge ☐ Prefilled Syringe
☐ AutoInjector ☐ Vial
☐ 50 mg ☐ 25 mg
☐ Once weekly SubQ ☐ Twice weekly SubQ
Qty: ☐ 4 ☐ 8 **Refills:**

HUMIRA® *(adalimumab)*
☐ Pen ☐ Prefilled Syringe
☐ Citrate Free(CF) ☐ Original Formula
☐ 40 mg SubQ every other week
☐ 40 mg SubQ once a week
Qty: 28 days **Refills:**

INFLECTRA® *(infliximab-dyyb)* 100 mg vials
☐ 3 mg/kg ☐ 5 mg/ kg ☐ 10 mg/ kg
☐ **Induction:** Give dose as an IV infusion at 0, 2, and 6 weeks
Qty: **Refills:**
☐**Maintenance:** Give dose as an IV infusion every __ weeks
Qty: **Refills:**

KEVZARA® *(sarilumab)* ☐ Pen ☐ Prefilled Syringe
☐ 150 mg ☐ 200 mg
Dosing: Inject SubQ every 2 weeks.
Qty: 2 **Refills:**

ORENCIA® *(abatacept)* ☐ 125 mg Prefilled Syringe
☐ 250 mg vial ☐ 125 mg autoinjector
☐ Inject 125 mg SubQ once a week.
☐ Infuse ___mg IV at Weeks 0, 2, and 4 then, every 4 weeks
Qty: 4 week supply **Refills:**

OLUMIANT® *(baricitinib)* ☐ 1 mg tablet ☐ 2 mg tablet
☐ Take 1 tablet by mouth daily
Qty: **Refills:**

OTEZLA® *(apremilast)*
☐ **Titration Pack**: Take by mouth as directed per package instructions
Qty: 1 Pack **Refills:** 0
☐ **Bridge Pack:** Take by mouth as directed per package instructions
Qty: 1 Pack **Refills:** 0
☐ **Maintenance:** 30 mg by mouth twice daily
Qty: 30 days **Refills:**

REMICADE® *(infliximab)* 100 mg vials ☐ Biosimilar authorized
☐ 3 mg/kg ☐ 5 mg/kg ☐ 10 mg/kg
☐ **Induction:** Give dose as an IV infusion at 0, 2, and 6 weeks
Qty: **Refills:** 2
☐ **Maintenance:** Give dose as an IV infusion every __ weeks
Qty: **Refills:**

RINVOQ® (upadacitinib) extended-release tablets
☐ 15 mg ☐ 30 mg
Once daily PO with or without food
Qty: **Refills:**

SIMPONI® *(golimumab)* 50 mg
☐ Prefilled Syringe ☐ Autoinjector
Inject SubQ once a month
Qty: 1 **Refills:**

SKYRIZI™ (risankizumab-rzaa)
☐ Prefilled Syringe ☐ Pen
☐ Inject 150 mg(1 injection) SubQ at Week 0, Week 4, and every 12 weeks thereafter.
Qty: 1 **Refills:**

STELARA® *(ustekinumab)*
☐ 45 mg Prefilled Syringe ☐ 90 mg Prefilled Syringe
Inject contents of 1 syringe SubQ on day 0, then week 4, then every 12 weeks
Qty: 1 **Refills:**

TALTZ® *(ixekizumab)* ☐ Autoinjector ☐ Prefilled Syringe
☐ Citrate Free(CF)
☐ **Psoriasis Induction:** Inject 160 mg (2 x 80 mg injections) SubQ at week 0; Inject 80 mg at weeks 2, 4, 6, 8 ,10, 12
Qty: 8 **Refills:**
☐ **Psoriatic Arthritis Induction**: Inject 160 mg (2 x 80 mg injections) SubQ at week 0
Qty: 2 **Refills:** 0
☐ **Maintenance:** 80 mg SubQ every 4 weeks
Qty: 1 **Refills:**

TREMFYA® *(guselkumab)*
☐ Prefilled Syringe ☐ Autoinjector
☐ **Induction:** Inject 100 mg SubQ weeks 0 and 4
Qty: 1 **Refills:** 1
☐ **Maintenance:** Inject 100 mg SubQ every 8 weeks
Qty: 1 **Refills:**

XELJANZ® *(tofacitinib)*
☐ 5 mg tablet ☐ 11 mg XR tabs
☐ Take one 5 mg tablet by mouth twice daily
☐ Take one 11 mg tablet by mouth once daily
Qty: **Refills:**

☐ **OTHER**

STRENGTH:

SIG/DIRECTIONS:

QUANTITY: **REFILLS:**

As required by your state, Prescriber to check "Dispense as written" or handwrite "Brand Medically Necessary" and sign to prevent generic substitution. ☐ Dispense as written

PHYSICIAN INFORMATION

Injection Training: ☐ Office to Instruct ☐ SP to Arrange Teaching

Prescriber Name:	Phone:	Fax:
Office Contact:	Email:	
Address:		Ship To: ☐ Patient ☐ MD Office
NPI #:	Tax ID#:	
Prescription Signature:		Date:

Your signature authorizes Southeast Health Specialty Pharmacy,LLC, and their network of pharmacies, to act on your behalf to obtain prior authorization, including appeals and peer to peer reviews, for the prescribed medications We will also pursue available copay and financial assistance on behalf of your patients. ©2023