

**RHEUMATOLOGY
 REFERRAL FORM**

Phone: 800-657-2212
Fax: 310-657-0906

Please FAX TO: 310-657-0906

Toll Free: 800-657-2212

Date Shipment needed _____

Ship To: Patient or Physician

PATIENT	PHYSICIAN
Patient Name: _____	Physician Name: _____
Address: _____	State Lic. #: _____ DEA# _____
City: _____ State: _____ Zip: _____	NPI: _____ Tax ID# _____
Home Phone : (____) ____ - ____ Cell(____) ____ - ____	Address: _____
Work Phone: (____) ____ - ____	City: _____ State: _____ ZIP: _____
Language Spoken: _____	Physician's Ph: (____) ____ - ____
Patient Soc. Sec #: _____	Physician's Fax: (____) ____ - ____
Date of Birth: _____	Nurse/Key Office Contact: _____
See attached demographic sheet	Specialty: _____ e-mail: _____

INSURANCE INFORMATION
 (Fax Pharmacy Card and/or write patient's pharmacy phone #)

CLINICAL INFORMATION

Diagnosis: _____ ICD-9 Codes: _____ Allergies: _____

Home Health Nurse Required: No Yes

Please list failed meds relevant to the diagnosis: **Please indicate all relevant lab results to the diagnosis:**

Med	dose	duration	reason to D/C		
_____	_____	_____	_____		
_____	_____	_____	_____		
_____	_____	_____	_____		
_____	_____	_____	_____		
_____	_____	_____	_____		

TB Test date and result: _____

ESR: _____ CRP: _____ Date: _____

Dexa Score: _____ Site: _____

Fracture: _____ Site: _____

Other Clinical Findings: _____

Evaluated for Hep-B: No Yes

TREATMENT	DOSE	DIRECTION	REFILLS
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<input type="checkbox"/> Actemra	400mg vials # __ , 200mg vials # __ , 80mg vials # __ , sig: ____ mg IV q 30days	_____	_____
<input type="checkbox"/> Benlysta	400mg vials # __ , 120mg vials # __	Initial dose: 10mg/kg ____ mg IV q2wks x first 3 doses Maintenance dose: ____ mg IVPB q 4 wks	_____
<input type="checkbox"/> Cimzia	200mg/vial #2, __ pfs or __ lyo pwdr	Initial dose: 400mg sq q0,2&4wks. 12 wks supply	_____
<input type="checkbox"/> Enbrel	50 mg/dose, 12 wks supply	sureclick __ sq qwk or __ 25 mg sq BIW	_____
<input type="checkbox"/> Forteo	600mcg/ 2.4 ml, 12wks supply x 2yrs	20 mcg sq qd, needle 31G/5mm # 100 PRN	_____
<input type="checkbox"/> Humira	40 mg/0.8ml 12 wks supply	pen __ sq q 2 weeks or __ sq weekly	_____
<input type="checkbox"/> Orencia	250 mg/vial	mg IVPB q __ , __ , __ , wks	_____
<input type="checkbox"/> Prolia	60mg vial #1	60mg sq every 6 months	_____
<input type="checkbox"/> Reclast	5 mg/100 ml #1	IVP once per year	_____
<input type="checkbox"/> Remicade	100 mg vls	mg IVPB q __ , __ , __ , wks	_____
<input type="checkbox"/> Rituxan	500 mg/vial	1000 MG IVPB on day 0 and day 14	_____
<input type="checkbox"/> Simponi	50mg/0.5ml, 12 wks supply	SmartJect or __ pfs, sq every 30 days	_____
<input type="checkbox"/> Other (specify): _____			

Comments: _____

Physician's Signature : _____ **Date :** _____

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