EL NORTE
Retail & Specialty Pharmacy

RHEUMATOLOGY REFERRAL FORM

Phone: (760) 233-2100
Fax: (760-233-2105

Ship To: ❑ Patient ❑ Physician / Clinic ❑ Pick Up ❑ Date Needed:_____ **Injection Training Needed:** ❑ Yes ❑ No

PATIENT INFORMATION				PRESCRIBER INFORMATION	
Patient Name				**Prescriber Name**	
Address				**NPI**	
City, State, Zip				**Address**	
Primary Phone		**Alt. Phone**		**City, State, Zip**	
Date of Birth		**Allergies**		**Office Phone:**	
Height/ Weight		**Sex:**	❑ Male ❑ Female	**Office Fax:**	
Insurance	**PLEASE FAX A COPY OF INSURANCE CARD(S)**			**Contact Person**	

CLINICAL INFORMATION

Diagnosis: ❑ Rheumatoid Arthritis ❑ Juvenile Arthritis ICD10 Code: _____ ❑ Other: _____ Disease Severity: ❑ Mild ❑ Moderate ❑ Severe

PPD/Chest X-Ray for TB ❑ Yes ❑ No Date of Negative TB test: _____ Does patient have active infection/malignancy? ❑ Yes ❑ No

Hepatitis B Test: ❑ Positive ❑ Negative Does patient have CHF? ❑ Yes ❑ No Does patient have liver/renal impairment? ❑ Yes ❑ No

Tried/Failed Previous Therapies: DMARDS ❑ Yes ❑ No Please List: _____ If no, please explain why: _____
Biologics: ❑ Yes ❑ No Please List: _____

PRESCRIPTION INFORMATION

MEDICATION	DOSE/ STRENGTH	DIRECTIONS	QUANTITY	REFILLS
❑ **ACTEMRA**	❑ 162 mg/0.9mL PFS	❑ For patients weighing < 100kg: Inject 162 mg SC every other week. ❑ For patients weighing > 100kg: Inject 162 mg SC once weekly ❑ Inject 162 mg once weekly		
❑ **CIMZIA**	❑ Cimzia Starter Kit (6 prefilled syringes)	❑ Induction Dose: Inject 400 mg SC on day 1, and week 2, and at week 4		
	❑ 200 mg/1mL PFS ❑ 200 mg vial	❑ Maintenance Dose: Inject 200 mg SC every other week ❑ Maintenance Dose: Inject 400 mg SC every 4 weeks ❑ Other: _____		
❑ **ENBREL**	❑ 25 mg vial ❑ 25 mg/0.5mL PFS ❑ 50 mg/mL Sureclick ❑ 50 mg/mL PFS	❑ Inject 25 mg SC twice weekly (72 to 96 hrs apart) ❑ Inject 50 mg SC once weekly ❑ Other: _____		
❑ **HUMIRA**	❑ 20 mg/0.8mL PFS ❑ 40 mg/0.8mL PFS ❑ 40 mg/0.8mL Pen	❑ Inject 20 mg SC every other week ❑ Inject 40 mg SC every other week ❑ Other:_____		
❑ **KEVZARA**	❑ 200 mg/1.14 mL PFS ❑ 150 mg/1.14 mL PFS	❑ Inject 200 mg SC every 2 weeks ❑ Inject 150 mg SC every 2 weeks		
❑ **ORENCIA**	❑ 125 mg PFS ❑ 125 mg/ml Click Jet Autoinjector	❑ Inject 125 mg SC every week		
	❑ 250 mg vial	❑ Infuse _____mg in 100mL OF 0.9%NCl at weeks 0, 2, and 4, then every 4 weeks thereafter		
❑ **OTEZLA**	❑ Titration Starter Pack	❑ Day 1: Take 10mg po QAM Day 2: Take 10mg po BID Day 3: Take 10mg po QAM and 20mg po QPM Day 4: Take 20mg po BID Day 5: Take 20mg po QAM and 30mg po QPM then take 30mg BID thereafter		
	❑ 30 mg tablets	❑ Take 30 mg by mouth twice daily		
❑ **REMICADE**	❑ 100 mg vial	❑ Induction Dose: Infuse _____ mg/kg in 250 mL of 0.9% NaCl at weeks 0, 2 and 6. ❑ Maintenance Dose: Infuse _____ mg/kg in 250 mL of 0.9% NaCl every _____ weeks.		
❑ **SIMPONI**	❑ 50 mg/0.5mL SmartJect Autoinjector ❑ 50 mg/0.5mL PFS	❑ Inject 50mg SC once every month		
❑ **STELARA**	❑ 45 mg/0.5mL PFS ❑ 90 mg/mL PFS	❑ For patients weighing ≤ 100 kg (220 lbs): Inject 45 mg SC initially and 4 weeks later, followed by 45 mg every 12 weeks ❑ For patients weighing > 100 kg (220 lbs): Inject 90 mg SC initially and 4 weeks later, followed by 90 mg every 12 weeks.		
❑ **XELJANZ** ❑ **XELJANZ XR**	❑ 5 mg tablets	❑ Take 5 mg by mouth twice daily		
	❑ 11 mg tablets	❑ Take 11 mg by mouth once daily		
❑ **OTHER**				

By signing below, I authorize El Norte Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process and help the patient to apply to co-pay assistance programs, including all foundations and manufacturer assistance programs if necessary.

Prescriber Signature: _____ Date: _____