Rheumatology Referral Form

357 Flatbush Ave • Brooklyn, NY 11238
Ph (718) 230-3535 • Fax (718) 230-0596 • Alt Fax (718) 230-0390

SHIP TO:	❑ Patient's Home	❑ Provider's Office	❑ Other:

PATIENT INFORMATION:

Patient Name (First):	Last:	M:	DOB (mm/dd/yy):	Sex: ❑M ❑F	Primary Language:
Patient Address: (include apt. #)			City:	State:	Zip:
Primary Phone:	Alternate Phone:		Allergies:	Height: ❑in ❑cm Weight: ❑lbs ❑kgs	

PHARMACY INSURANCEINFORMATION: **Please include a copy of the front/back of the pharmacy insurance card with this form**

Primary Insurance Name:	Insured's SSN:	Patient ID#:
Rx BIN#:	Rx PCN#:	Rx Group#:

PRESCRIBING PHYSICIAN INFORMATION:

Physician Name:	Specialty:	Contact Name:
Physician Address:	Phone #:	Secure Fax #:
Physician DEA # :	Physician NPI #:	License #:

CLINICALINFORMATION:

Diagnosis/ICD-10:
❑ Rheumatoid Arthritis (M06.9)
❑ Ankylosing Spondylitis (M45.9)
❑ Psoriatic Arhtirits (L40.5)
❑ Other: ________________________________

Date of diagonsis: ________________________

Other Clinical Information:
- Is pateint taking methotrexate? ❑ Yes ❑ No
- TB/PPD test given? ❑ Yes ❑ No
  Date of negative test: ________________
- HBV Positive? ❑ Yes ❑ No
- If no, has treatment been initiated?
  ❑ Yes ❑ No

Current/Prior Therapies:
Please include medication name/strength, duration of tx, and reason for discontinuation
____
____
____
____

PRESCRIPTION INFORMATION: **Please include an original prescription or E scribe a prescription to Kings Pharmacy**

Medication	Dose/Strength	Directions	Quantity	Refills
❑ ACTEMRA®	❑ 162 mg/0.9 mL PFS	❑ 162 mg SQ every OTHER week ❑ 162 mg SQ ONCE a week	❑ 2 PFS ❑ 4 PFS	
❑ CIMZIA®	**Starter Dose:** ❑ Starter Kit (6 x 200 mg PFS) ❑ 200 mg lyophilized vial **Maintenance Dose:** ❑ 200 mg/mL PFS ❑ 200 mg lyophilized vial	❑ 400 mg SQ at weeks 0, 2, 4 ❑ 400 mg SQ every 4 weeks ❑ 200 mg SQ every 2 weeks	❑ 1 kit ❑ 3 kits ❑ 4-week supply	
❑ ENBREL®	❑ 50 mg/mL SureClick® ❑ 50 mg/mL PFS ❑ 25 mg/0.5 mL PFS ❑ 25 mg vial	❑ Inject 50 mg SQ ONCE a week ❑ Inject 25 mg SQ TWICE a week ❑ Other: ____________________________	❑ 4-week supply	
❑ FORTEO®	❑ 250 mcg/2.4 mL PFS	❑ Inject 20 mcg SQ daily as directed	❑ 4-week supply	
❑ HUMIRA®	❑ 40 mg/0.8 mL PEN ❑ 40 mg/0.8 mL PFS	❑ Inject 40 mg SQ every OTHER week ❑ Inject 40 mg SQ ONCE a week ❑ Other: ____________________________	❑ 4-week supply	
❑ ORENCIA®	❑ 250 mg vial (IV use) ❑ 125 mg/mL PFS	❑ Loading dose: 10 mg/kg IV x 1 dose, then 125 mg SQ weekly, start within 24 hours of IV dose ❑ 125 mg SQ ONCE a week	❑ 1 dose ❑ 4-week supply	
❑ OTEZLA®	❑ Starter Pack ❑ 30 mg tablet	❑ Day 1: 10 mg AM; Day 2: 10 mg AM, 10 mg PM; Day 3: 10 mg AM, 20 mg PM; Day 4: 20 mg AM, 20 mg PM; Day 5: 20 mg AM; 30 mg PM; Day 6 and thereafter: 30 mg TWICE daily as indicated on pack ❑ 30 mg PO TWICE daily	❑ 55 tablets (one 4-week pack) ❑ 60 tablets	
❑ PROLIA®	❑ 60 mg/mL PFS	❑ Inject 60 mg SQ ONCE every 6 months	❑ 1 PFS	
❑ SIMPONI®	❑ 50 mg/0.5 mL Autoinjector ❑ 50 mg/0.5 mL PFS ❑ 50 mg/4 mL vial	❑ Inject 50 mg SQ ONCE monthly ❑ 2 mg/kg IV infusion over 30 min at week 0 ❑ 2 mg/kg IV infusion over 30 min at week 4 and every 8 weeks therafter	❑ 1 dose ❑ ______ vial(s)	
❑ STELARA®	❑ 45 mg/0.5 mL PFS ❑ 90 mg/mL PFS	❑ Inject contents of 1 PFS SQ on day 1 ❑ Inject contents of 1 PFS SQ starting day 29 & every 12 weeks thereafter	❑ 1 PFS	
❑ XELJANZ®	❑ 5 mg tablet	❑ 5 mg PO TWICE daily	❑ 60 tablets	
❑ Other				

PRESCRIBER SIGNATURE: **DATE:**

CONFIDENTIALITY STATEMENT: This communication is intended for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential and exempt from disclosure under applicable law. If the reader of this communication is not the intended recipient or the employee or agent responsible for delivery of the communication, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone.