



PharmaCare Specialty Pharmacy Rheumatology Referral Form

FAX REFERRAL TO: 800-447-3694
Phone: 800-990-9247

Date: _____ Needs by Date: _____ • Ship to Patient Office Training at PharmaCare

PATIENT INFORMATION

(Complete the following *or send patient demographic sheet*)

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Alternate Phone: _____
SS#: _____
Date of Birth: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____
State License #: _____ DEA#: _____
Group or Hospital: _____
Address: _____
City, State, Zip: _____
Phone: _____
Fax: _____
Contact Person: _____

INSURANCE INFORMATION

Primary Insurance/
Prescription Card:

PLEASE FAX COPY OF INS CARD
(FRONT & BACK)

Secondary Insurance/
Prescription Card:

PLEASE FAX COPY OF INS CARD
(FRONT & BACK)

CLINICAL INFORMATION

(OPTIONAL - but will assist in insurance authorization and patient education)

Diagnosis:

714.0 Rheumatoid Arthritis 720.0 Ankylosing Spondylitis
 733.0 Osteoporosis 696.0 Psoriatic Arthritis
 715.9 Osteoarthritis (Unspecified)

Other Clinical Info/Comments:

- *General*: Is patient also taking methotrexate? Yes No
- *Humira®/Enbrel®*: TB/PPD Test given? Yes No
- *Enbrel®*: Does patient have a latex allergy? Yes No
- *Forteo®*:
 - T-Score: _____ Date: _____
 - Fracture History: Site: _____ Date: _____
Site: _____ Date: _____
- *Orencia®/Remicade®/Rituxan®*: WEIGHT: _____ lbs or _____ kgs
- Comments: _____

Prior (FAILED) Medications:

Medication	Duration of Treatment/Reason for D/C
<input type="checkbox"/>	_____
<input type="checkbox"/>	_____
<input type="checkbox"/>	_____

• Comments: _____

PRESCRIPTION INFORMATION

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
<input type="checkbox"/> Humira®	<input type="checkbox"/> 40mg/0.8ml PEN <input type="checkbox"/> 40mg/0.8ml Prefilled Syringe	<input type="checkbox"/> Inject 40mg SC every OTHER week <input type="checkbox"/> Inject 40mg SC ONCE a week	4-week supply	_____
<input type="checkbox"/> Enbrel®	<input type="checkbox"/> 50mg/ml Sureclick™ Autoinjector <input type="checkbox"/> 50mg/ml Prefilled Syringe <input type="checkbox"/> 25mg Vial (<i>inj. supplies incl</i>)	<input type="checkbox"/> Inject 50mg SC ONCE a week <input type="checkbox"/> _____ <input type="checkbox"/> Inject 25mg SC TWICE a week	4-week supply	_____
<input type="checkbox"/> Forteo® <input type="checkbox"/> B-D 31 gauge 5mm PEN NEEDLES	750ug/3ml Pen	Inject 20ug (0.08ml) SC as directed ONCE a day Use as directed with Forteo® Pen	4-week supply 100 (1 box)	_____
<input type="checkbox"/> Kineret®	100mg Prefilled Syringe	Inject 100mg (0.67ml) SC QD	4-week supply	_____
<input type="checkbox"/> Orencia®	250mg Vial	<input type="checkbox"/> Infuse _____ mg at weeks 0, 2, and 4, then every 4 weeks thereafter. <input type="checkbox"/> Other: _____	_____ (# of vials)	_____
<input type="checkbox"/> Remicade®	100mg Vial <input type="checkbox"/> 5mg/kg <input type="checkbox"/> _____ mg/kg	<input type="checkbox"/> IV at 0, 2, and 6 weeks (<i>induction</i>) <input type="checkbox"/> IV every 8 weeks (<i>maintenance</i>) <input type="checkbox"/> IV every _____ weeks	_____ (# of vials)	_____
<input type="checkbox"/> Rituxan®	<input type="checkbox"/> 100mg/10ml vial <input type="checkbox"/> 500mg/50ml vial	<input type="checkbox"/> Infuse 1000mg IV once a month <input type="checkbox"/> Other: _____	_____ (# of vials)	_____
<input type="checkbox"/>	_____	_____	_____	_____

Patient Support Programs:

I authorize PharmaCare Specialty Pharmacy to enroll me in the pharmaceutical company-assisted patient support program, corresponding with my prescribed therapy for purposes of receiving additional services such as, but not limited to, injection training. I further authorize PharmaCare to release and communicate to the corresponding manufacturer the minimum necessary information about my health condition and prescription(s) to: coordinate the delivery of products and services available through the patient assistance program, aggregate de-identified data for market analysis and provide educational information regarding therapies. I understand I may revoke this authorization at anytime in writing by sending a letter to PharmaCare Pharmacy, Privacy Office, 600 Penn Center Blvd. Pittsburgh, PA 15235. I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment from the pharmacy. However, I will not be enrolled in the service program listed above. A copy of this authorization will be utilized with the same effectiveness as an original.

• Patient Signature (required): _____ Date: _____ My Humira® Enliven (Enbrel®)

Prescriber Signature

Do not Substitute

IMPORTANT NOTICE: This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee. Revised 10/10/06 RA Abbott