Rheumatology Referral Form

THE HONOLULU PHARMACY
COMPOUNDING PHARMACY & SPECIALTY PHARMACY

Phone: 808-533-8887
Fax: 808-533-1888
E-Prescribing Available

Attention: _____ Need By Date: _____ First Ship To: ☐ Patient ☐ Physician

Patient

Patient Name: _____ DOB: _____ Sex: ☐ Male ☐ Female
Address: _____ City: _____ State: _____ Zip: _____
Home#: _____ Work #: _____ Cell#: _____ Best time to call: ☐ AM ☐ PM
Soc. Sec #: _____ Ethnicity: _____ Primary Language: _____
Comorbidities: _____ Height: _____ Weight: _____ Date: _____
Allergies: _____ ☐ NKDA

Provider

Physician Name: _____ Practice Name: _____ State Lic#: _____ DEA#: _____
Address: _____ City: _____ State: _____ Zip: _____ NPI#: _____
Phone#: _____ Fax#: _____ Nurse/Key Office Contact: _____ Ext.: _____

Insurance

Primary Insurance: _____ ID: _____ Phone: _____
Secondary Insurance: _____ ID: _____ Phone: _____
* Please provide a copy of the insurance card (front and back) and MEDICATION LIST

Clinical Info

Diagnosis:
☐ M06.9 Rheumatoid Arthritis (RA) ☐ mild ☐ moderate to severe
☐ M08.20 Juvenile Idiopathic Arthritis (JIA)
☐ Other ICD 10 _____

Has the patient had a NEGATIVE tuberculin skin test, or if positive, has therapy for latent TB been initiated prior to anti-TNF therapy? ☐ yes ☐ no

Does the patient have a clinically important active infection? ☐ yes ☐ no

Prior Failed Medication (s):	Length of Treatment:	Reason for Discontinuing:
1.		
2.		
3.		

Prescription

Medication	Strength	Directions	Quantity	Refill
☐ **Actemra**® (tocilizumab) 20 mg/ml	_____mg	☐ Infuse once every 4 weeks	_____doses	
☐ **Forteo**® (teriparatide) injection	☐ 20 mg	☐ subcutaneously every day for 28 days ☐ subcutaneously every day for _____	_____doses	
☐ **Cimzia**® Lyophilized Powder ☐ **Cimzia**® Pre Filled Syringe	☐ Inject 400 mg subcutaneously at weeks 0.2 & 4 (induction) ☐ Inject 400 mg subcutaneously every 4 weeks (maintenance) ☐ Inject 200 mg subcutaneously every other week (maintenance)		_____doses	
☐ **Enbrel**® (etanercept) PFS ☐ **Enbrel**® (etanercept) SureClick Autoinjector	☐ 50 mg subcutaneously once weekly ☐ 0.8 mg/kg/wk subcutaneously once weekly (JIA) (please fill in weight section) ☐ _____		_____ kits	
☐ **Humira**® (adalimumab) PFS ☐ **Humira**® (adalimumab) Pen	☐ 22 mg ☐ 44 mg	☐ subcutaneously every other week ☐ _____	_____ kits	
☐ **Orencia**® (abetacept) Vials ☐ **Orencia**® (abetacept) Pre-filled Syringe	☐ _____ mg (Please ensure weight is given above for dose verification) ☐ 125 mg PFS	☐ IV at 0, 2, & 4 weeks (induction) ☐ IV every 4 weeks (maintenance) ☐ IV every _____ weeks ☐ 125 mg inject SQ w/in a day of IV Orencia ☐ Inject 125 mg SQ once every week	_____ vials ☐ 4 Syringes	
☐ **Remicade**® (infliximab)	☐ 3 mg/kg ☐ _____mg/kg	☐ IV at 0, 2, & 6 weeks (induction) ☐ IV every 8 weeks (maintenance) ☐ IV every _____ weeks	_____ vials	
☐ **Rituxan**® (rituximab)	10 mg/mL, 50 ml vial (500 mg)	☐ Infuse 1000 mg IV and follow with a second dose of 1000 mg IV in 2 weeks ☐ _____	☐ 4 vials (2 doses) ☐ _____ vials	
☐ **Simponi** ™ (Golimumab)	☐ 50 mg/0.5 ml single dose SmartJect autoinjector ☐ 50 mg/0.5 ml single dose PFS	☐ Subcutaneously once monthly	_____doses	
☐ **Xeljanz**®	☐ Tablet	☐ Take 5 mg twice daily	☐ 60 tablets	
☐ **Stelara** ™ (Ustekinumab) Single-use Prefilled Syringe	☐ 45 mg subcutaneously at week 0 and week 4 (≤ 220 pounds) ☐ 90 mg subcutaneously at week 0 and week 4 (> 220 pounds) ☐ 45 mg subcutaneously every 12 weeks (≤ 220 pounds) ☐ 90 mg subcutaneously every 12 weeks (> 220 pounds)		_____doses	
☐ **Other:** _____				

Physicians Signature: _____ Date: _____

I authorize The Honolulu Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.