

Rheumatology Referral Form



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: <input type="checkbox"/> Male <input type="checkbox"/> Female
	Address: _____ City: _____ State: _____ Zip: _____
	Home#: _____ Work #: _____ Cell#: _____ Best time to call: <input type="checkbox"/> AM <input type="checkbox"/> PM
	Soc. Sec #: _____ Ethnicity: _____ Primary Language: _____
	Comorbidities: _____ Height: _____ Weight: _____ Date: _____
	Allergies: _____ <input type="checkbox"/> 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: <input type="checkbox"/> M06.9 Rheumatoid Arthritis (RA) <input type="checkbox"/> mild <input type="checkbox"/> moderate to severe <input type="checkbox"/> M08.20 Juvenile Idiopathic Arthritis (JIA) <input type="checkbox"/> 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? <input type="checkbox"/> yes <input type="checkbox"/> no Does the patient have a clinically important active infection? <input type="checkbox"/> yes <input type="checkbox"/> no
	Prior Failed Medication (s):	Length of Treatment:
	Reason for Discontinuing:	
	1. _____	

Prescription

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

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