

RHEUMATOLOGY REFERRAL FORM

Non-Infusion Drug Names Starting with A - H Prescriber, please sign and fax completed form to 713.704.3841 For questions, please call 281.698.6100

SHIP	□ Patient
TO:	☐ Office (1st dose)
	☐ Office (All doses)

Patient Information	**Pleas	se include copy	of prescription	and medical	nsurance card, front ar	nd back**			
Patient Name:				Dat	e of Birth:				
Street Address:	Phone:			ne:					
City, State, Zip:				Alle	rgies:				
Prescriber Information									
				ND					
Prescriber Name: Specialty:				NPI	: ne:				
Office Street Address:				Fax		·			
City, State, Zip:					ce Contact:				
Patient Medical Informat	ion **	Please include	copies of any	pertinent clinic	al notes and lab work	**			
Diagnosis (ICD-10):	☐ M06.9 (Rheun	natoid Arthritis) □ L4	0.59 (Psoriation		□ M45.9	(Ankylosing Spondylit		
Diagnosis Date:	•	•	,	•	est X-ray (if TB positive)				
Previous and/or Current					, , ,				
Medication Name(s)		Current Use	Start Date	End Date	Discontinue Reason (if	stopped)			
					☐ Failed ☐ Other Expla				
					□ Failed □ Other Expla	anation:			
					☐ Failed ☐ Other Expla	anation:			
Prescription Information					Quantity		Form	Refills	
☐ Actemra (tocilizumab)	□ Inject 162 mg s □ Inject 162 mg s		•		□ #2 (162 mg □ #4 (162 mg		☐ Auto Injector☐ PFS	Refills:	
☐ Amjevita	Adult Inject 40 mg sul Inject 40 mg sul Inject 80 mg sul	eekly		□ #2 (40 mg / 0.8 □ #4 (40 mg / 0.8	· · · · · · · · · · · · · · · · · · ·	☐ Auto Injector ☐ PFS	D-fill-		
(adalimumab-atto)	Pediatric ☐ Inject 20 mg sul ☐ Inject 40 mg sul			□ #2 (20 mg / 0.4 □ #2 (40 mg / 0.8	· · · · · · · · · · · · · · · · · · ·	☐ Auto Injector (40 mg only) ☐ PFS	l l		
Cimaio	Initial (if applicable ☐ Inject 400 mg s	at weeks 0, 2,	and 4	□ #6 (200 mg / n	nL)	PFS	No Refills		
☐ Cimzia (certolizumab)	Maintenance (Star ☐ Inject 200 mg s ☐ Inject 400 mg s	every 2 weeks		<u>e)</u> □ #2 (200 mg / m	ıL)	PFS	Refills:		
☐ Cosentyx	Initial (if applicable) ☐ Inject 150 mg subcutaneously at weeks 0, 1, 2, 3 ☐ Inject 300 mg subcutaneously at weeks 0, 1, 2, 3				□ #4 (150 mg / m □ #8 (150 mg / m	· .	☐ Auto Injector ☐ PFS	No Refills	
(secukinumab)	Maintenance (Starting on week 4 after initial dose, if applicable) ☐ Inject 150 mg subcutaneously every 4 weeks ☐ Inject 300 mg subcutaneously every 4 weeks				<u>e)</u> □ #1 (150 mg / m □ #2 (150 mg / m		☐ Auto Injector ☐ PFS	Refills:	
☐ Enbrel (etanercept)	☐ Inject 50 mg subcutaneously weekly ☐ Inject 25 mg subcutaneously two times per week ☐ Inject 50 mg subcutaneously two times per week ☐ Inject mg (0.8 mg / kg x weight in kg) subQ weekly				□ #4 (50 mg / ml □ # (25 mg /	· .	☐ Auto Injector ☐ Mini Cartridge ☐ PFS ☐ Vial	Refills:	
☐ Humira (adalimumab)	Adult ☐ Inject 40 mg subcutaneously every 2 weeks ☐ Inject 40 mg subcutaneously weekly				□ #2 (40 mg / 0.4 □ #4 (40 mg / 0.4		☐ Pen ☐ PFS	Refills:	
Pediatric □ Inject 10 mg subcutaneously every 2 weeks □ Inject 20 mg subcutaneously every 2 weeks □ Inject 40 mg subcutaneously every 2 weeks			□ #2 (10 mg / 0.1 □ #2 (20 mg / 0.2 □ #2 (40 mg / 0.4	2 mL)	☐ Pen (40 mg only) ☐ PFS (all doses)	Refills:			
Dunnanih au Circust	Channe Barrier								
Prescriber Signature (No	Stamps Permitted)								

By signing below, I authorize Memorial Hermann Specialty Pharmacy to serve as my designated agent, if needed, to initiate and execute any applicable authorization processes with medical and prescription insurance companies. To prohibit generic substitution write "brand necessary" or "brand medically necessary" on the face of the referral form in your own handwriting. Prescriber's Signature:

Date:

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RHEUMATOLOGY REFERRAL FORM

Non-Infusion Drug Names Starting with K – S Prescriber, please sign and fax completed form to 713.704.3841 For questions, please call 281.698.6100

SHIP	□ Patient
TO:	☐ Office (1st dose)
	☐ Office (All doses)

Patient Information	**Pleas	se include copy	of prescription	and medical	insura	nce card, front and back**		
Patient Name:	Date of			te of B	f Birth:			
Street Address:	Phone:			one:	:			
City, State, Zip:	Allergie			ergies:				
Prescriber Information								
Prescriber Name:				NP	l:			
Specialty:				Pho	one:			
Office Street Address:				Fax	(:			
City, State, Zip:				Off	ice Co	ntact:		
Patient Medical Informat	ion	**Please inclu	de copies of a	ny pertinent cl	linical	notes and lab work **		
Diagnosis (ICD-10):	☐ M06.9 (Rheur			0.59 (Psoriation 0.54 (Psoriat			.9 (Ankylosing Spondylit r	tis)
Diagnosis Date:	•	•	*	•				
Previous and/or Current	Medications Used to	Treat this Diag	(nosis:					
Medication Name(s)		Current Use	Start Date	End Date	Disco	ntinue Reason (if stopped)		
					☐ Fai	led \square Other Explanation:		
						led Other Explanation:		
					☐ Fai	led ☐ Other Explanation:		
Prescription Information					Q	uantity	Form	Refills
☐ Kevzara (sarilumab)	□ Inject 150 mg s □ Inject 200 mg s					□ #2 (150 mg / 1.14 mL) □ #2 (200 mg / 1.14 mL)	☐ Auto Injector ☐ PFS	Refills:
☐ Methotrexate	☐ Take tablets by mouth times weekly ☐ Inject mg subcutaneously weekly					□ # (mg tablet) □ #4 (mg / mL)	☐ Tablet ☐ Otrexup Injector ☐ Rasuvo Injector ☐ RediTrex Injector	Refills:
☐ Olumiant (baricitinib)	☐ Take 1 tablet by mouth daily					□ #30 (2 mg tablet)	Tablet	Refills:
☐ Orencia (abatacept)	□ Inject 125 mg subcutaneously weekly					□ #4 (125 mg / mL)	□ Auto Injector □ PFS	Refills:
□ Otezla	Initial (if applicable) ☐ Take as directed on the package instructions					☐ #55 (28-day starter)	Tablet	No Refills
(apremilast)	Maintenance ☐ Take 1 tablet by mouth twice daily					□ #60 (30 mg tablet)	Tablet	Refills:
☐ Prednisone	☐ Take tablets by mouth times daily					# (mg tablet)	Tablet	Refills:
☐ Rinvoq (baricitinib)	☐ Take 1 tablet by mouth daily					☐ #30 (15 mg tablet)	Tablet	Refills:
☐ Simponi (golimumab)	☐ Inject 50 mg subcutaneously once a month] #1 (50 mg / 0.5 mL)	□ Auto Injector □ PFS	Refills:
☐ Skyrizi	Initial (if applicable) ☐ Inject 150 mg subcutaneously once					□ #1 (150 mg / mL)	□ Auto Injector □ PFS	No Refills
(risankizumab)	Maintenance (Starting 4 weeks after initial dose, if applicable) □ Inject 150 mg subcutaneously every 12 weeks) [□ #1 (150 mg / mL)	□ Auto Injector □ PFS	Refills:
☐ Stelara	Initial (if applicable) ☐ Inject 45 mg subcutaneously once ☐ Inject 90 mg subcutaneously once					☐ #1 (45 mg / 0.5 mL) ☐ #1 (90 mg / mL)	□ PFS	No Refills
(ustekinumab)	Maintenance (Starting 4 weeks after initial dose, if applicable) ☐ Inject 45 mg subcutaneously every 12 weeks ☐ Inject 90 mg subcutaneously every 12 weeks					☐ #1 (45 mg / 0.5 mL) ☐ #1 (90 mg / mL)	□ PFS	Refills:

Prescriber Signature (No Stamps Permitted)

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RHEUMATOLOGY REFERRAL FORM

Non-Infusion Drug Names Starting with T - Z Prescriber, please sign and fax completed form to 713.704.3841 For questions, please call 281.698.6100

SHIP	□ Patient
TO:	☐ Office (1st dose)
	☐ Office (All doses)

Patient Information	**Pleas	se include copy	of prescription	and medical	ins	urance card, front and bac	(* *		
Patient Name: Street Address: City, State, Zip:				Ph	ite o ione lergi				
Prescriber Information									
Prescriber Name: Specialty: Office Street Address: City, State, Zip:	NPI: Phone: Fax:				: Contact:				
Patient Medical Informa				pertinent clini	ical	notes and lab work **			
Diagnosis (ICD-10):	 ☐ M06.9 (Rheur ☐ M08.0 (Juveni 			0.59 (Psoriati				.9 (Ankylosing Spond r	
Diagnosis Date:	•	-	*	•		t X-ray (if TB positive):			
Previous and/or Current									
Medication Name(s)		Current Use	Start Date	End Date	Dis	scontinue Reason (if stopp	ed)		
					$\overline{}$	Failed Other Explanation			
					-	Failed Other Explanation:			
						Failed Other Explanation	า:	_	
Prescription Information						Quantity		Form	Refills
☐ Taltz ☐ Initial (if applicable ☐ Inject 160 mg (e) 2 x 80 mg) subcutaneously once				□ #2 (80 mg / mL)		☐ Auto Injector ☐ PFS	No Refills
(ixekizumab)	Maintenance (Starting 4 weeks after initial dose, if applicable) ☐ Inject 80 mg subcutaneously every 4 weeks)	□ #1 (80 mg / mL)		☐ Auto Injector ☐ PFS	Refills:
☐ Tremfya	Initial (if applicable) ☐ Inject 100 mg subcutaneously once					□ #1 (100 mg / mL)		☐ Auto Injector ☐ PFS	No Refills
(guselkumab)	Maintenance (Starting 4 weeks after initial dose, if applicable) ☐ Inject 100 mg subcutaneously every 8 weeks			□ #1 (100 mg / mL)		☐ Auto Injector ☐ PFS	Refills:		
☐ Xatmep (methotrexate)	☐ Take mg one time weekly.					☐ 2.5 mg/ml		Oral Solution	
☐ Xeljanz (tofacitinib)	☐ Take 1 tablet by mouth twice daily					□ #60 (5 mg tablet)		Tablet	Refills:
☐ Xeljanz XR (tofacitinib)	☐ Take 1 tablet by mouth daily					□ #30 (11 mg tablet)		Tablet	Refills:
☐ Xeljanz – oral solution (tofacitinib)	☐ Take 3.2 mg by mouth twice daily ☐ Take 4 mg by mouth twice daily ☐ Take 5 mg by mouth twice daily				☐ #1 (1 mg / mL)		240 mL bottle	Refills:	
☐ Other:						#			Refills:

Prescriber Signature (No Stamps Permitted)	
By signing below, I authorize Memorial Hermann Specialty Pharmacy to serve as my designated agent, if need	eded, to initiate and execute any applicable authoriza-
tion processes with medical and prescription insurance companies. To prohibit generic substitution write "bra	and necessary" or "brand medically necessary" on the
face of the referral form in your own handwriting.	
Prescriber's Signature :	Date: