MEMORIAL HERMANN Specialty Pharmacy

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

Patient Information

Please include copy of prescription and medical insurance card, front and back

Patient Name: _____ Date of Birth: _____

Street Address: _____ Phone: _____

City, State, Zip: _____ Allergies: _____

Prescriber Information

Prescriber Name: _____ NPI: _____

Specialty: _____ Phone: _____

Office Street Address: _____ Fax: _____

City, State, Zip: _____ Office Contact: _____

Patient Medical Information

**Please include copies of any pertinent clinical notes and lab work **

Diagnosis (ICD-10): ☐ M06.9 (Rheumatoid Arthritis) ☐ M45.9 (Ankylosing Spondylitis) ☐ L40.54 (Psoriatic Juvenile Arthritis) ☐ L40.59 (Psoriatic Arthritis) ☐ M08.0 (Juvenile Idiopathic Arthritis) ☐ Other _____

Diagnosis Date: _____ Date of negative TB Test: _____ Date of negative chest X-ray (if TB positive): _____

Previous and/or Current Medications Used to Treat this Diagnosis:

Medication Name(s)	Current Use	Start Date	End Date	Discontinue Reason (if stopped)
	☐			☐ Failed ☐ Other Explanation:_____
	☐			☐ Failed ☐ Other Explanation:_____
	☐			☐ Failed ☐ Other Explanation:_____

Prescription Information

Prescription Information		Quantity	Form	Refills
☐ **Actemra** (tocilizumab)	☐ Inject 162 mg subcutaneously weekly ☐ Inject 162 mg subcutaneously every 2 weeks	☐ #4 (162 mg / 0.9 mL) ☐ #2 (162 mg / 0.9 mL)	PFS	Refills:____
☐ **Cimzia** (certolizumab)	Initial (if applicable) ☐ Inject 400 mg subcutaneously at weeks 0, 2, and 4	☐ #6 (200 mg / mL)	PFS	No Refills
	Maintenance (Starting [ ] weeks after initial dose, if applicable) ☐ Inject 200 mg subcutaneously every 2 weeks ☐ Inject 400 mg subcutaneously every 4 weeks	☐ #2 (200 mg / mL)	PFS	Refills:____
☐ **Cosentyx** (secukinumab)	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 / mL) ☐ #8 (150 mg / mL)	☐ Auto Injector ☐ PFS	No Refills
	Maintenance (Starting on week 4 after initial dose, if applicable) ☐ Inject 150 mg subcutaneously every 4 weeks ☐ Inject 300 mg subcutaneously every 4 weeks	☐ #1 (150 mg / mL) ☐ #2 (150 mg / mL)	☐ 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 / mL)	☐ Auto Injector ☐ Mini Cartridge ☐ PFS ☐ Vial	Refills:____
☐ **Humira** 40mg / 0.8 mL (adalimumab)	Adult ☐ Inject 40 mg subcutaneously every 2 weeks ☐ Inject 40 mg subcutaneously weekly	☐ #2 (40 mg / 0.8 mL) ☐ #4 (40 mg / 0.8 mL)	☐ 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 / 0.2 mL) ☐ #2 (20 mg / 0.4 mL) ☐ #2 (40 mg / 0.8 mL)	☐ Pen (40mg only) ☐ PFS (all doses)	Refills:____
☐ **Humira Citrate Free** 40mg / 0.4 mL (adalimumab)	Adult ☐ Inject 40 mg subcutaneously every 2 weeks ☐ Inject 40 mg subcutaneously weekly	☐ #2 (40 mg / 0.4 mL) ☐ #4 (40 mg / 0.4 mL)	☐ 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 mL) ☐ #2 (20 mg / 0.2 mL) ☐ #2 (40 mg / 0.4 mL)	☐ Pen (40mg only) ☐ PFS (all doses)	Refills:____
☐ methotrexate	☐Take ____ tablets by mouth _____ times weekly ☐Inject ____ mg subcutaneously weekly	☐ #____ (____ mg tablet) ☐ #4 (____mg / ____ mL)	☐ Tablet ☐ Vial ☐ Otrexup Injector ☐ Rasuvo Injector	Refills:____
☐ prednisone	☐Take ____ tablets by mouth _____ times daily	☐ #____ (____ mg tablet)	Tablet	Refills:____

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 prescription in your own handwriting.

Prescriber's Signature : _____ Date: _____

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	☐			☐ Failed ☐ Other Explanation:_____
	☐			☐ Failed ☐ Other Explanation:_____

Prescription Information

Prescription Information		Quantity	Form	Refills
☐ **Kevzara** (sarilumab)	☐ Inject 150 mg subcutaneously every 2 weeks ☐ Inject 200 mg subcutaneously every 2 weeks	☐ #2 (150 mg / 1.14 mL) ☐ #2 (200 mg / 1.14 mL)	PFS	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** (apremilast)	Initial (if applicable) ☐ Take as directed on the package instructions	☐ #55 (28-day starter)	Tablet	No Refills
	Maintenance ☐ Take 1 tablet by mouth twice daily	☐ #60 (30 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:____
☐ **Stelara** (ustekinumab)	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
	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:____
☐ **Taltz** (ixekizumab)	Initial (if applicable) ☐ Inject 160 mg (2 x 80 mg) subcutaneously once	☐ #2 (80 mg / mL)	☐ Auto Injector ☐ PFS	No Refills
	Maintenance (Starting 4 weeks after initial dose, if applicable) ☐ Inject 80 mg subcutaneously every 4 weeks	☐ #1 (80 mg / mL)	☐ Auto Injector ☐ PFS	Refills:____
☐ **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:____
☐ **Other: _____**	_____	#_____	_____	Refills:____
☐ methotrexate	☐Take ____ tablets by mouth _____ times weekly ☐Inject ____ mg subcutaneously weekly	☐ #____ (____ mg tablet) ☐ #4 (____mg / ____ mL)	☐ Tablet ☐ Vial ☐ Otrexup Injector ☐ Rasuvo Injector	Refills:____
☐ prednisone	☐ Take ____ tablets by mouth _____ times daily	☐ #____ (____ mg tablet)	Tablet	Refills:____

Prescriber Signature (no stamps permitted)

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