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) ☐ L40.59 (Psoriatic Arthritis) ☐ M45.9 (Ankylosing Spondylitis)
☐ M08.0 (Juvenile Idiopathic Arthritis) ☐ L40.54 (Psoriatic Juvenile 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

		Quantity	Form	Refills
☐ Actemra (tocilizumab)	☐ Inject 162 mg subcutaneously every 2 weeks ☐ Inject 162 mg subcutaneously weekly	☐ #2 (162 mg / 0.9 mL) ☐ #4 (162 mg / 0.9 mL)	☐ Auto Injector ☐ PFS	Refills: ___
☐ Amjevita (adalimumab-atto)	Adult ☐ Inject 40 mg subcutaneously every 2 weeks ☐ Inject 40 mg subcutaneously weekly ☐ Inject 80 mg subcutaneously every 2 weeks	☐ #2 (40 mg / 0.8 mL) ☐ #4 (40 mg / 0.8 mL)	☐ Auto Injector ☐ PFS	Refills: ___
	Pediatric ☐ Inject 20 mg subcutaneously every 2 weeks ☐ Inject 40 mg subcutaneously every 2 weeks	☐ #2 (20 mg / 0.4 mL) ☐ #2 (40 mg / 0.8 mL)	☐ Auto Injector (40 mg only) ☐ PFS	
☐ 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 (adalimumab) ■ Hyrimoz ■ Simlandi	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 (40 mg only) ☐ PFS (all doses)	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 referral form in your own handwriting.

Prescriber's Signature : _____ Date: _____

MEMORIAL HERMANN Specialty Pharmacy

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 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) ☐ L40.59 (Psoriatic Arthritis) ☐ M45.9 (Ankylosing Spondylitis)
☐ M08.0 (Juvenile Idiopathic Arthritis) ☐ L40.54 (Psoriatic Juvenile 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		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)	☐ 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 (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: ___
☐ 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 (risankizumab)	Initial (if applicable) ☐ Inject 150 mg subcutaneously once	☐ #1 (150 mg / mL)	☐ Auto Injector ☐ PFS	No Refills
	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 (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: ___

Prescriber Signature (No Stamps Permitted)

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Prescriber's Signature : _____ Date: _____

MEMORIAL HERMANN Specialty Pharmacy

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 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) ☐ L40.59 (Psoriatic Arthritis) ☐ M45.9 (Ankylosing Spondylitis)
☐ M08.0 (Juvenile Idiopathic Arthritis) ☐ L40.54 (Psoriatic Juvenile 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
☐ 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: ___
☐ Tremfya (guselkumab)	Initial (if applicable) ☐ Inject 100 mg subcutaneously once	☐ #1 (100 mg / mL)	☐ Auto Injector ☐ PFS	No Refills
	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)

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Prescriber's Signature : _____ Date: _____