Pharmax SPECIALTY PHARMACY

RHEUMATOID ARTHRITIS REFERRAL FORM

TEL 813.880.2500
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TOLL FREE 1.866.880.2507

PATIENT INFORMATION

Name:_____ Address:_____ _____ _____ Phone:_____

SSN:_____ DOB:_____ Sex:_____

Weight:_____ Height:_____ Allergies:_____ Ship to: ☐ Patient ☐ Clinic

INSURANCE

Prescription Card: _____ Name of Insurer:_____ ID#_____ BIN:_____ PCN:_____

Group:_____ (please attach copies of insurance cards)

DIAGNOSIS

LCD-10:_____ ☐ M06.9 Rheumatoid Arthritis ☐ M08.0 Juvenile Idiopathic Arthritis ☐ M45.9 Ankylosing Spondylitis ☐Other

ICD-9 Code:_____ Prior Failed Therapy:_____ Start Date:_____ End Date:_____

Reason for DC:_____ Has TB test been done? ☐Yes ☐No

Test Result:_____ Date:_____

Does the patient have an active infection? ☐Yes ☐No

Current Medications:_____

PRESCRIPTION INFORMATION

Medication	Dose	Directions	Quantity	Refill
☐ Actemra (Tocilizumab)	☐ 162 mg/0.9ml PFS	☐ Inject 162 mg every other week ☐ Inject 162 mg every week ☐ Other	☐ 2 X 162 mg/0.9 ml ☐ 4 X 162 mg/0.9 ml	
☐ Cimzia (Certolizumab)	☐ 200 mg/ml PFS ☐ 200 mg vials	☐ Initial: inject 400 mg SC at 0, 2 and 4 weeks	☐ 6 x 200 mg/ml	0
		Maintenance: ☐ Inject 200 mg SC every 2 wks. ☐ Inject 400 mg SC every 4 wks. ☐ Other _____	☐ 2 x 200 mg/ml	
☐ Enbrel (Etanercept)	☐ 50 mg/ml auto-injector ☐ 25 mg/0.5 ml PFS ☐ 50 mg/ml PFS	☐ Inject 50 mg SC once weekly ☐ Inject 25 mg SC twice a week ☐ Other _____	☐ 4 x 50 mg/ml ☐ 8 x 25 mg/0.5ml	
☐ Humira (Adalimumab)	☐ 40 mg /0.8 ml pens ☐ 40 mg /0.8 ml PFS	☐ Inject 40 mg SC every other week ☐ Inject 40 mg SC every week ☐ Other _____	☐ 2 x 40 mg/0.8 ml ☐ 4 x 40 mg/0.8 ml	
☐ Keneret (Anakinra)	☐ 100 mg /0.67 PFS	☐ Inject 100 SC once daily		
☐ Orencia (Abatacept)	☐ 125 mg /ml PFS	☐ Inject 125 mg SC weekly ☐ Other _____	☐ 4 x 125 mg/ml	
☐ Otezla (Apremilast)	☐ Starter pack	☐ Follow package insert directions	☐ 1 starter pack (55 tablets)	0
	☐ 30 mg tab	Maintenance: ☐ Take 30 mg by mouth twice daily ☐ Other _____	☐ 60 tablets	
☐ Simponi (Golimumab)	☐ 50 mg /0.5 ml autoinjector ☐ 50 mg /0.5 ml PFS	☐ Inject 50 mg SC once a month	☐ 1 x 50 mg/0.5 ml	
☐ Stelara (Ustekinumab)	☐ 45 mg /0.5 ml PFS ☐ 90 mg /ml PFS Dosing: ☐ ≤100Kg: 45 mg ☐ >100 Kg: 90 mg	☐ Inject 45 mg SC at weeks 0 and 4 ☐ Inject 90 mg SC at weeks 0 and 4 Maintenance: ☐ Inject 45 mg sc every 12 weeks ☐ Inject 90 g SC every 12 weeks	☐ 2 x 45 mg/0.5 ml ☐ 2 x 90 mg/ml ☐ 1x 45 mg/0.5 ml ☐ 1 x 90 mg/ml	0
☐ Xeljanz (Tofacitinib)	☐ 5 mg tablet	☐ Take 5 mg by mouth twice daily	☐ 60 tablets	
☐ Xeljanz XR	☐ 11 mg tablet	☐ Take 1 tablet by mouth once daily	☐ 30 tablets	

PRESCRIBER INFORMATION

Physicain Name:_____ Address:_____

State License#:_____ NPI:_____ DEA:_____

Phone #:_____ Fax #:_____ Office Contact Name /Number:_____

Prescriber's Signature:_____ Date:_____

I authorize pharmax specialty pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.