ameripharma SPECIALTY CARE

Rheumatology Referral Form

Phone#: 877-778-0318 Fax#: 877-778-0399

Patient Information

Patient Name: _____ DOB: _____ Sex: ☐ Male ☐ Female SSN: _____ Wt (kg/lbs): _____ Ht (cm/in): _____

Address: _____ Phone: _____ Alternate: _____

Caregiver Name: _____ Relation to Patient: _____ Phone: _____

Insurance Plan: _____ Plan ID: _____ BIN #: _____ PCN #: _____ GRP #: _____

Please fax a copy of the front and back of the insurance card(s).

Prescriber + Shipping Information

Prescriber Name: _____ DEA: _____ NPI: _____

Address: _____

Phone: _____ Alternate: _____ Fax: _____ Email: _____

If shipping to prescriber: ☐ First Fill ☐ Always ☐ Never

Clinical Information (Please fax all pertinent clinical and lab information)

Diagnosis: ☐ M06.9 (Rheumatoid Arthritis) ☐ M08.0 (Juvenille Idiopathic Arthritis) ☐ L40.59 (Psoriatic Arthritis) ☐ L40.54 (Psoriatic Juvenille Arthritis) ☐ M45.9 (Ankylosing Spondylitis) ☐ _____

Diagnosis Date: _____ TB Test: ☐ Yes ☐ No Negative Test Date: _____

Prior Therapy ☐ Yes ☐ No	Reason for Discontinuation of Therapy	Start Date	End Date

Comorbidities: _____

Concomitant Medications: _____

Allergies: ☐ NKDA ☐ Other: _____

Prescription	Directions, Quantity, Form			Refill
☐ **Inflectra®** (infliximab) ☐ **Remicade®** (infliximab) ☐ **Renflexis®** (infliximab)	☐ Inject _____ mg (5mg/kg x _____ kg) IV at 0, 2, and 6 weeks, then every _____ weeks thereafter ☐ In conjunction with Methotrexate: Inject _____ mg (3mg/kg x _____ kg) IV at 0, 2, and 6 weeks, then every _____ weeks thereafter			
☐ **Krystexxa®** (pegloticase injection) 8mg/mL	☐ Inject 8mg via intravenous infusion every 2 weeks			
☐ **Methotrexate®**	☐ Inject _____ mL subq every 7 days at the same time each week		☐ 25mg/mL Injectable Solution	
☐ **Orencia®** (abatacept)	☐ Infuse _____ mg at week 0 **only** ☐ Infuse _____ mg at weeks 0 and 2	☐ _____ x 250 mg	☐ Vials	0
	(JIA <75 kg: 10 mg/kg; JIA ≥75 kg or RA:<60 kg: 500 mg, 60-100 kg: 750 mg; >100 kg: 1000 mg)			
	☐ Infuse _____ mg at week 4 and every 4 weeks thereafter	☐ _____ x 250 mg	☐ Vials	
	(JIA <75 kg: 10 mg/kg; JIA ≥75 kg or RA:<60 kg: 500 mg, 60-100 kg: 750 mg; >100 kg: 1000 mg)			
☐ **Simponi Aria®** (golimumab)	☐ Infuse _____ mg (2 mg/kg x _____ kg) over 30 minutes at weeks 0	☐ _____ x 50 mg/4ml	☐ Vials	0
	☐ Infuse _____ mg (2 mg/kg x _____ kg) over 3 minutes at week 4 and every 8 weeks thereafter	☐ _____ x 50 mg/4ml	☐ Vials	

Injection Training Provided by: ☐ Prescriber's Office ☐ Pharmacy ☐ Other: _____

Per state-specific law, prescriptions will be dispensed as generic, if applicable, unless notated otherwise: _____

Prescriber's Signature: _____ Date: _____

I authorize AmeriPharma and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above.
I understand that I can revoke this designation at any time by providing written notice to AmeriPharma.

Reset Form