



RHEUMATOLOGY REFERRAL FORM

Start Date

Single Point of Contact: 724-515-7053 Pharmacy 866-213-9821

FAX: 877-526-8823

Ship To: ☐ Patient ☐ Office ☐ Other**1. Patient Information:**

Please fax front and back copy of the insurance card (Prescription and Medical)

Patient: _____ Male / Female DOB: _____ Soc. Sec. # _____
First Name Last Name
Address: _____
Street City State Zip
Primary phone number: _____ Alternate phone number: _____
Caregiver: _____ Allergies: _____
Comorbidities: _____ Height: _____ Weight: _____

2. Clinical Information:

Please fax recent clinical notes, Labs, Tests, with prescription to expedite the prior authorization

ICD-10/ Diagnosis Code:

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

Date of negative TB test: _____ Any prior treatment: ☐ NO ☐ YES (provide information below) Allergies: ☐ NKDA ☐ Other: _____

Prior Therapy	Reason for Discontinuation of Therapy	Approximate Start Date	Approximate End Date

3. Prescription Information:

If you need a medication not listed please contact us

Medication	Strength	Directions	Quantity	Refills
<input type="checkbox"/> Actenra®	<input type="checkbox"/> 162mg/0.9 mL PFS	<input type="checkbox"/> 162mg Sub-Q every other week <input type="checkbox"/> 162mg Sub-Q once a week	<input type="checkbox"/> 2 PFS <input type="checkbox"/> 4 PFS	
<input type="checkbox"/> Cimzia®	Starter Dose; <input type="checkbox"/> Starter Kit (200mg PFS) <input type="checkbox"/> 200mg Lyophilized Vial	<input type="checkbox"/> 400mg Sub-Q at weeks 0,2, and 4	<input type="checkbox"/> 1Kit=6x200 mg/mL PFS <input type="checkbox"/> 3 Cartons =2x200mg Lyophilized Vials	
	Maintenance Dose; <input type="checkbox"/> 200mg/mL PFS <input type="checkbox"/> 200mg Lyophilized Vial	<input type="checkbox"/> 400mg Sub-Q every 4 weeks <input type="checkbox"/> 200mg Sub-Q every 2 weeks	<input type="checkbox"/> 1 Carton=2x200mg/mL PFS <input type="checkbox"/> 1 Carton=2x200mg Lyophilized Vials	
<input type="checkbox"/> Enbrel®	<input type="checkbox"/> 50mg/mL Sureclick® <input type="checkbox"/> 50mg/mL PFS <input type="checkbox"/> 25mg/.0.5mL PFS	<input type="checkbox"/> Inject 50mg Sub-Q once a week(≥63 kg) <input type="checkbox"/> Other: _____	<input type="checkbox"/> 1 Carton =4 SureClicks® <input type="checkbox"/> 1 Carton=4 PFS	
<input type="checkbox"/> Humira®	<input type="checkbox"/> 40mg/0.8 mL Pen <input type="checkbox"/> 40mg/0.8 mL PFS	<input type="checkbox"/> Inject 40mg Sub-Q every other week <input type="checkbox"/> Inject 40mg Sub-Q once a week <input type="checkbox"/> Other: _____	<input type="checkbox"/> 1 Carton=2 x 40mg devices <input type="checkbox"/> 2 Carton= 4 x 40mg devices <input type="checkbox"/> Other: _____	
<input type="checkbox"/> Orencia®	<input type="checkbox"/> 250mg Vial (IV use only) <input type="checkbox"/> 125mg/mL PFS	<input type="checkbox"/> Other _____ <input type="checkbox"/> 125mg Sub-Q once a week	<input type="checkbox"/> Vials _____ <input type="checkbox"/> 4 Syringes	
<input type="checkbox"/> Otezla®	Starter Dose; <input type="checkbox"/> 4 week starter pack	<input type="checkbox"/> Day 1: 10mg AM; Day2: 10mg AM. 10mg PM. Day3: 10mg AM 20mg PM: Day4: 20mg AM, 20mg PM: Day5 20mg AM, 30mg PM: Day6 and thereafter 30mg twice daily(as indicated on starter pack packaging)	<input type="checkbox"/> 1 four week starter pack	
	Maintenance Dose; <input type="checkbox"/> 30mg tablet	<input type="checkbox"/> 30mg twice daily <input type="checkbox"/> other: _____	<input type="checkbox"/> 60 tablets <input type="checkbox"/> Other	
<input type="checkbox"/> Simponi®	<input type="checkbox"/> 50mg/0.5mL SmartJect® <input type="checkbox"/> 50mg/0.5 mL PFS	<input type="checkbox"/> Inject 1 dose (50mg) Sub-Q once monthly	<input type="checkbox"/> 1 x 50 mg device	
<input type="checkbox"/> Simponi® Aria™	Starter Dose; <input type="checkbox"/> 50mg (4mL) vial(s)	<input type="checkbox"/> 2mg/kg IV infusion over 30 minutes at Week 0	<input type="checkbox"/> _____ Vial(s)	
	Maintenance Dose: <input type="checkbox"/> 50mg (4mL) vial (s)	<input type="checkbox"/> 2mg/kg IV infusion over 30 minutes at Week 4 and every 8 weeks thereafter	<input type="checkbox"/> _____ Vial(s)	
<input type="checkbox"/> Stelara®	<input type="checkbox"/> 45mg/0.5mL PFS <input type="checkbox"/> 90mg/1 mL PFS	Initiation Dose: <input type="checkbox"/> Inject 1 PFS Sub-Q Day 1	<input type="checkbox"/> 1 PFS	
		Maintenance Dose: <input type="checkbox"/> Inject the contents of 1 PFS Sub-Q starting Day 29 & every 12 weeks thereafter	<input type="checkbox"/> 1 PFS	
<input type="checkbox"/> Xeljanz®	<input type="checkbox"/> 5mg tablet	<input type="checkbox"/> Take 1 tablet by mouth twice daily	<input type="checkbox"/> 60 tablets <input type="checkbox"/> Other	

4. Prescriber and Shipping Information

Prescriber (print): _____ Office Contact: _____
Preferred method of contact: ☐ phone ☐ fax ☐ email preferred contact persons email: _____
Office Address: _____
Phone: _____ fax: _____ NPI: _____ DEA: _____
Prescriber's Signature: _____ Date: _____

I authorize AccuServ Pharmacy and its representative to act as an agent to initiate and execute the insurance prior authorization process. (NO STAMPS)

5. Patient Support Programs (optional):

Please sign below to enroll in the pharmaceutical company assisted patient support program

Patient Signature: _____ Date: _____

6. Insurance Information:

Please fax a copy of the insurance card (front & back)

*IMPORTANT NOTICE: this fax is intended to be delivered only to the named address. It contains materials that are confidential, privileged, proprietary or exempt from disclosure under applicable law. If you are not the named address you should not disseminate distribute or copy this fax. Please notify the sender immediately if you received this document in error and destroy this document immediately. Please fax completed form to AccuServ Pharmacy at 877-526-8823. Visit us at WWW.ACCUSERVPHARMACY.COM for online fillable forms.