BARNERT PHARMACY
"FAST, FRIENDLY, DEPENDABLE SERVICE"

RHEUMATOLOGY REFERRAL FORM

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Paterson, NJ 07514

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Patient Information

Patient Name ____________________ Today's Date__________ ☐ *NEW* Patient ☐ *CURRENT* Patient
DOB__________ Height ________ Weight ________ ☐ Male ☐ Female Preferred Language ____________
Best Phone ____________________ Email ____________________
Street Address____________________ Apt#________ City__________ State__________ Zip________
Ship to Patient at: ☐ Home ☐ Physician Office ☐ Work Address
Allergies____________________
Current Medications including OTC's (*please fax a complete list*)____________________

Please Fax Insurance Card(s) both sides

Insured's Name ____________________
Relation to Patient ____________________

Primary Insurance ____________________
ID# __________ Group#__________
Secondary Insurance ____________________
ID# __________ Group#__________

Ordering Prescriber

Office Contact ____________________
Street Address ____________________ Suite #__________
City __________ State__________ Zip__________
Tel __________ Fax __________
Email ____________________
License#____________________
NPI# ____________________

Diagnostic & Clinical Information

ICD-10 Diagnosis Code: ☐ L40.59 Psoriatic Arthritis ☐ M32.10 SLE ☐ M06.9 Rheumatoid Arthritis ☐ M45.9 Ankylosing Spondylitis
☐ M19.90 Osteoarthritis (Unspecifed site) ☐ M81.0 Osteoporosis (age-related, w/o current fracture) ☐ Other __________
Previously treated for this condition? ☐ **Yes** ☐ **No** Medication(s) failed____________________
Patient currently taking Methotrexate? ☐ **Yes** ☐ **No** For Humira/Enbrel: PPD (TB Test) ☐ **Yes** ☐ **No**
Does patient have latex allergy (for Enbrel)? ☐ **Yes** ☐ **No** Rheumatoid Factor Positive__________ Total Swollen Joints__________
For Forteo: T-Score__________ Date__________ Fracture History: Site__________ Date__________

Prescription

HUMIRA® (adalimumab) Patient weight (kg)__________
Dose: ☐ 40mg/0.8ml PFS ☐ 40mg/0.8ml PEN
Dispense: ☐ Inject 40mg subcutaneously every OTHER week
☐ Inject 40mg subcutaneously ONCE a week
Qty: 4 week supply Refill__________

ENBREL® (etanercept)
☐ SureClick™ Autoinjector 50mg ☐ Prefilled Syringe 50mg
☐ Multiuse Vial 25mg (injection supplies included)
Dispense: ☐1 x week ☐2 x week Qty: 4 week supply Refill__________

FORTEO® ☐ 750ug/3ml Pen Inject 20mcg SQ Daily as directed
QTY: 4 week supply Refill__________
☐ B-D 31 gauge 5mm PEN NEEDLES Use as directed w/ Forteo pen
QTY: 100 (1 box) Refill__________

KINERET® (anakinra) ☐ 100mg PFS Inject 100mg (0.67ml) SQ QD
QTY: 4 week supply Refill__________

ORENCIA® ☐ 125mg PFS ☐ 250mg Vial ☐ 125mg ClickJect™
☐ Inject 125mg SC weekly
☐ Infuse__________ mg,____________________
☐ Infuse__________ mg at weeks, 0,2 and 4, then every 4 weeks thereafter
☐ Other____________________
QTY: 4 week supply Refill__________ CARTON OF 4 AUTOINJECTORS

TYMLOS® ☐ 3120mcg/1.56ml ☐ 80 mcg SC once daily into periumbilical region; give with supplemental calcium and vitamin ☐ if dietary intake is not adequate. 1 pre-filled pen:__________ (Refills)

STELARA ®
Starting Dose: ☐ 45mg ☐ 90mg
SQ initially & 4 weeks later
Maintenance Dose: ☐ 45mg ☐ 90mg
SQ every 12 weeks

REMICADE® ☐ 100mg Vial ☐ 5mg/kg ☐ ________mg/kg
☐ IV on weeks 0, 2 and 6 (induction)
☐ IV every 8 weeks (Maintenance Dose)
☐ IV every__________weeks
QTY:________# of vials Refill__________

SIMPONI® ☐ SmartJect™ PEN 50mg/0.5ml ☐ PFS 50mg/0.5ml
☐ Inject 50mg subcutaneously once per month
QTY: 1 month supply Refill__________

KEVZARA® ☐ 150mg/1.14ml PFS ☐ 200mg/1.14ml PFS
☐ Inject 200mg SC once every 2 weeks
Other:____________________
4-week supply:__________ (Refills)

CIMZIA® ☐ 200mg/1ml PFS ☐ 50mg/200mg Vial
☐ **Initial Dose:** Inject 400mg SQ on day 1, at week 2 & at week 4
☐ **Maintenance Dose:** Inject 200mg SQ every OTHER week
☐ **Maintenance Dose:** Inject 400mg SQ every OTHER week
☐ Other____________________
QTY__________ Refill__________

PROLIA® ☐ 60mg PFS ☐ 60mg Vial
☐ Inject 60mg subcutaneously every 6 months QTY: 1 Refill__________

RECLAST® ☐ 5mg/100ml Vial
☐ 5mg IV once yearly QTY: 1 Refill__________

By signing this form I authorize Barnert Pharmacy and its representatives to act as my agent in order to initiate and execute the insurance prior authorization process and, in doing so release clinical information via phone to the appropriate third party payer.

____________________ **Prescriber's signature** (no stamps) if brand required check this ☐ DAW____ **Date**__________