DR. IKE'S PHARMACY
ADVANCED SPECIALTY PHARMACY

RHEUMATOLOGY
REFERRAL FORM

Fax: **888.804.7717**

Ship To: ❑ Patient ❑ Physician/Clinic Date Shipment Needed: _____ **Rx**: ❑ New ❑ Refill _____

PATIENT INFORMATION

Patient's Full Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Alt. Phone: _____
Patient SS#: _____
DOB: _____
Allergies: _____
Gender: ❑ Male ❑ Female
Primary Insurance: _____
ID#: _____ Phone: _____
Secondary Insurance: _____
ID#: _____ Phone: _____

PLEASE FAX COPY OF INSURANCE CARD (FRONT & BACK)

- ❑ Rheumatoid Arthritis ❑ Ankylosing Spondylitis ❑ Juvenile RA (JIA) ❑ other
- Severity index: ❑ Mild ❑ Moderate ❑ Severe
- Has patient been treated previously for this condition? ❑ No ❑ Yes
  Medication/therapy failed (length of therapy): _____
  Therapies: _____
- Is patient currently in therapy? ❑ Yes ❑ No
  Type / Medications: _____
- Will patient terminate current therapy upon start of new prescription?
  ❑ Yes ❑ No
- How long should the patient wait before starting the new drug therapy?
  _____
- Other medications patient is currently taking including
  OTC medications with dosage and direction (or fax medication profile):
  _____

Has patient received a PPD (tuberculosis) Skin Test? ❑ Yes ❑ No

Results: _____ ICD-9 Code: _____

MEDICATION	DOSE/STRENGTH	SIG	QTY.	REFILLS
☐ **Actemra**	☐ 162mg/0.9ml PFS	☐ Inject 1 syringe SC every week ☐ Inject 1 syringe SC every other week	4-week supply	
☐ **Enbrel**	☐ 50mg/ml SureClick™ Autoinjector ☐ 50mg/ml Prefilled Syringe ☐ 25mg Prefilled Syringeek	☐ Inject 50mg SC ONCE a week ☐ Inject 25mg TWICE a week, 72 to 96 hours apart ☐ Other:	4-week supply	
☐ **Humira**	☐ 40mg/0.8ml Pen ☐ 40mg/0.8ml Prefilled Syringe	☐ Inject 40mg SC every OTHER week ☐ Inject 40mg SC ONCE a week	4-week supply	
☐ **Orencia**	☐ 125mg/ml Prefilled Syringe (4 syringes)	☐ Inject 125mg SC ONCE weekly	VIALS	
☐ **Cimzia Initial Dose**	☐ 200mg Starter Kit (contains 6, 200mg PFS)	☐ Inject 400mg SC once, then repeat at weeks 2 and 4 (NDC 50474-0710-81)	4-week supply	NO REFILLS
☐ **Cimzia Maintenance Treatment**	☐ 2 x 200mg Prefilled Syringe (NDC 50474-0710-9)	☐ 200mg SC ONCE every TWO weeks ☐ 400mg SC ONCE every FOUR weeks	4-week supply	
☐ **Simponi**	☐ 50mg/0.5ml Prefilled Syringe ☐ 50mg/0.5ml Autoinjector	☐ Inject 50mg ONCE a month	4-week supply	
☐ **Simponi, Aria**	☐ Infuse 2mg/Kg IV at week 0, 4 then every 8 weeks			
☐ **Remicade**	☐ 100mg Vial # of Vials_____			
☐ **Rituxan**	☐ 100mg Vial # of Vials_____			
☐ **Xeljanz**	☐ 5mg	☐ Take 5mg TWICE daily	#60	
☐ **Otezla**	☐ 30mg ☐ Bridge RX Has patient received Titration Starter Pack ☐ Yes ☐ No	☐ 1 tablet/twice daily ☐ Take as instructed	#60 #55	
☐ **Other**				

PRESCRIBER INFORMATION

Physician's Name (Please Print): _____ NPI#: _____
Address: _____ License#: _____
City, State, Zip: _____ DEA#: _____
Phone: _____ Fax: _____ Contact Name: _____
Physician's Signature: _____ Date: _____

I authorize Dr. Ike's Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.