RHEUMATOLOGY (A-J) PRESCRIPTION REFERRAL FORM

REALO X SPECIALTY CARE PHARMACY

Community Consultant Contact:

Fax referral to: 844-814-1944 Phone: 844-814-1943
Email referral form to: connect@realospecialtycare.com
For additional forms, visit realospecialtycare.com.

PATIENT INFORMATION

Patient Name: _____ ❑Male ❑Female SS#: _____ DOB: _____
Address: _____ City, State, Zip: _____
Primary Phone: _____ ❑Home ❑Cell ❑Work Alternate Phone: _____ ❑Home ❑Cell ❑Work
Email: _____ Height: _____ Weight: _____
Allergies: _____ Comorbidities: _____

PRESCRIBER INFORMATION

Prescriber Name: _____ Office Contact: _____
Address: _____ City, State, Zip: _____
Phone: _____ Fax: _____
NPI: _____ DEA: _____

SHIPPING INFORMATION

Ship To: ❑Patient ❑Physician/Clinic ❑Realo Location: _____
Date Shipment Needed By: _____ ❑Alternate Location: _____
Shipping Address City, State, Zip

DIAGNOSIS AND CLINICAL INFORMATION (Please fax recent clinical notes, labs, and tests to expedite PA)

Diagnosis: ❑M06.9 Rheumatoid Arthritis ❑L40.50 Psoriatic Arthritis
❑M08.0 Juvenile Idiopathic Arthritis ❑Other: _____
❑M45._____ Ankylosing Spondylitis

Is patiently currently on RA Therapy? ❑yes ❑no Medications: _____ Prior Failed Medications:
TB/PPD test given? ❑yes ❑no Does patient have a latex allergy? ❑yes ❑no

PRESCRIPTION INFORMATION

MEDICATION	DOSE	QUANTITY	REFILL	DIRECTIONS
❑Actemra®	❑162mg/0.9mL prefilled Syringe	4-week supply		❑Inject 162mg SubQ every OTHER week ❑Inject 162mg SubQ ONCE a week
❑Cimzia®	❑200mg/mL prefilled Syringe	4-week supply		❑Initial: Inject 400 mg SubQ, Repeat dose 2 and 4 weeks after initial dose ❑Inject 200mg SubQ every other week ❑Inject 400mg SubQ every 4 weeks
❑Cosentyx® ❑Injection Training	Starter Dose: ❑Sensoready Pen ❑150 mg PFS ❑2 x 150 mg (300mg) PFS	❑4 boxes		❑150 mg Sub-Q once weekly for 5 weeks ❑300 mg Sub-Q once weekly for 5 weeks
	Maintenance Dose: ❑Sensoready Pen ❑150 mg PFS ❑2 x 150 mg (300mg) PFS	❑1 box		❑150 mg Sub-Q every 4 weeks ❑300 mg Sub-Q every 4 weeks
❑Enbrel®	❑50mg/mL SureClick™ Autoinjector ❑50mg/mL Prefilled Syringe ❑25mg/0.5mL Prefilled Syringe ❑Mini 50mg Prefilled Cartridge ❑25mg vial	4-week supply		❑Inject 50mg SubQ ONCE a week ❑Inject 25mg TWICE a week, 72 to 96 hours apart ❑Other: _____
❑Humira® ❑Citrate Free	❑40mg Pen ❑40mg Prefilled Syringe	4-week supply		❑Inject 40mg SubQ every OTHER week ❑Inject 40mg SubQ ONCE a week

Prescriber Signature: I authorize Realo Specialty Care Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

Dispense As Written - Signature | Date | Substitution Permissable - Signature | Date

PLEASE FAX COPY OF INSURANCE CARD (FRONT + BACK) AND MEDICATION LIST TO 844-814-1944.