



RHEUMATOLOGY (A-J) PRESCRIPTION REFERRAL FORM

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

PRESCRIPTION INFORMATION

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

Date

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

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