REALO SPECIALTY CARE PHARMACY

RHEUMATOLOGY (K-Z) 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 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
❑Kevzara®	❑150mg/1.14mL Prefilled Syringe ❑200mg/1.14mL Prefilled Syringe	4-week supply		❑Inject 125mg SubQ every other week ❑Inject 200mg SubQ every other week
❑Olumiant®	❑2mg tablet	30 tablets		❑Take 1 tablet (2mg) by mouth daily
❑Otezla®	Starter Dose: ❑4-week starter pack	❑One 4 week starter pack		Day 1: 10 mg AM; Day 2: 10 mg AM, 10 mg PM; Day 3: 10 mg AM, 20 mg PM; Day 4: 20 mg AM, 20 mg PM; Day 5: 20 mg AM, 30 mg PM; Day 6 and thereafter: 30 mg twice daily (as indicated on starter pack packaging)
	Bridge Program Dose Pack: ❑30 mg tablet	❑28-count carton of 30 mg tablets (two blister cards containing 14 tablets each)		❑30mg PO once daily (renal impairment)
	Maintenance Dose: ❑30 mg tablet	❑60 tablets		❑30 mg PO twice daily
❑Orencia®	❑125mg/mL ClickJet Auto-Injector ❑125mg/mL Prefilled Syringe	4-week supply		❑Inject 125mg SubQ every week
❑Otrexup®/Rasuvo®	________mL Auto-Injector	4-week supply		________mL every week
❑Pen Needles	❑31 gauge 6mm	28 needles		
❑Rinvoq®	❑15mg	30 tablets		❑Take 1 tablet by mouth daily
❑Simponi®	❑50mg/0.5ml Prefilled Syringe ❑50mg/0.5ml Autoinjector	4-week supply		❑Inject 50mg ONCE a month
❑Xeljanz®	❑5mg tablet ❑11mg XR tablet	30 day supply		❑5mg tablet by mouth twice daily ❑11mg XR tablet by mouth once daily

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.

IMPORTANT NOTICE: This message may contain information which may be proprietary and confidential. It may also contain privileged, confidential information which is exempt from disclosure under applicable laws, including the Health and Accountability Act (HIPAA). If you are not the intended recipient, please note that you are strictly prohibited from disseminating or distributing this information (other than to the intended recipient). Please notify the sender immediately if you have received this document in error. Copyright © 2020 by Realo Drugs. All rights reserved.