Rheumatology Referral Form

4915 BROADWAY, NEW YORK, NY 10034, TEL: 212-304-4646
FAX: 212-304-0759, Toll Free Number: 1-844-295-8203,
Email: inwoodpharma@gmail.com, Web: www.inwoodpharmacy.com

PATIENT INFORMATION

Patients Name :	SSN#:		DOB:	
Address:	City:	State:		Zip:
Home Phone:	Cell Phone:	Height:	Weight:	Gender: Male Female
Email Address:	Diagnosis Code:			

INSURANCE INFORMATION (or attach copy of your cards)

Primary Insurance Co:	RxBIN:	RxPCN:	RxGroup:	RxID:	Phone:
Secondary Insurance Co:	RxBIN:	RxPCN:	RxGroup:	RxID:	Phone:

DIAGNOSIS/CLINICAL INFORMATION(Please FAX recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization)

Diagnosis: Other: _____
Prior failed medications (medication and duration of treatment/reason for d/c):
_____
_____
Is patient currently on RA therapy? O Yes O No
Medications: _____
TB/PPD test given? O Yes O No

BMD/T-score: _____ Date: _____
Does patient have a latex allergy? O Yes O No
Is Patient at risk for osteoporotic fracture as evident by any of the following?
- ☐ History of osteoporotic fracture Site:_____Date: _____
- ☐ Patient has tried and failed an oral bisphosphonate
- ☐ Patient has documented contraindication/is intolerant to oral bisphosphonate therapy(please submit a copy of DEXA w/prescription)

PRESCRIPTION INFORMATION (or attach copy of your prescription)

HUMIRA (adalimumab)	Dosing: ☐ 40 mg/0.8 mL pen ☐ 40 mg/0.8 mL Prefilled Syringe	Directions: ☐ 40mg SubQ Every Other Week ☐ Other:_____	Qty: _____ Refills:_____
ENBREL (etancercept)	Dosing: ☐ 25 mg/0.5 mL Prefilled Syringe ☐ 25 mg Multi Dose Vial ☐ 50 mg/mL Prefilled Syringe ☐ 50 mg/mL SureClick™ Autoinjector	Directions: ☐ Inject 50 mg SubQ Twice Weekly ☐ Inject 50 mg SubQ Once a Week ☐ Inject 25 mg SubQ Twice Weekly ☐ Other:_____	Qty: _____ Refills:_____
REMICADE (infliximab)	Dosing: ☐ 100 mg Vial add patient weight __ kg	Directions: ☐ 3 mg/kg (# _____100 mg vials). Intravenously Weeks 0, 2 and 6 Then Every 8 Weeks Thereafter. ☐ Other_____	Qty: _____ Refills:_____
SIMPONI (golimumab)	Dosing: ☐ 50 mg ☐ 100 mg ☐ 50 Smartject	Directions: ☐ Inject 50 mg SubQ Once A Month	Qty: _____ Refills:_____
CIMZIA certolizumab pegol)	Dosing: ☐ 200 mg/mL Prefilled Syringe	induction Dosing 2 x200 mg/mL SubQ at Week 1, 2x200mg/mL at Week 2 and Week 4	Qty: 6 x 200 mg/mL 3 Packs (no Refills)
		Maintenance Dosing: (select one) 2 x 200mg/ml SubQ every 4 weeks 2 x 200mg/ml SubQ every 2 weeks	Qty: _____ Refills:_____
RITUXAN (rituximab)	Dosing: ☐ 100 mg Vial ☐ 500 mg Vial	Directions: ☐ _____	Qty: _____ Refills:_____
XELJANZ (tofacitinib)	Dosing: ☐ 5 mg Tablet	Directions: ☐ Take one tablet by mouth twice daily ☐ Other	Qty: _____ Refills:_____
ACTEMRA (tocilizumab)	Dosing: ☐ 80 mg/4 mL ☐ 200 mg/10 mL ☐ 400 mg/20 mL		Qty: _____ Refills:_____

Prescriber Name:	Phone:	Fax:	
Office Address:	Email:	NPI#:	
DEA#:	LIC#:	☐ Dispense as written:	Date
Prescriber Signature :		Deliver To : ☐ M D Office ☐ Patient Home	

Your signature authorizes the pharmacy to act on your behalf to obtain prior authorization for the prescribed Medications. We will also pursue available copay and financial assistance on behalf of your patients.