BioMatrix SpRx

RA & INFLAMMATION REFERRAL FORM

TODAY'S DATE _____

☐ **CURRENT PATIENT** ☐ **NEW PATIENT**

PLEASE FAX REFERRAL FORM TO:

☐ **BiologicTx - NJ**
TEL: 877-567-8087 FAX: 877-567-8089

☐ **BiologicTx - CA**
TEL: 800-404-1963 FAX: 800-404-4595

☐ **BiologicTx - IL**
TEL: 888-892-7607 FAX: 877-567-8089

☐ **Decillion Healthcare**
TEL: 800-622-9321 FAX: 866-548-8849

☐ **Elwyn Specialty Care**
TEL: 855-359-9679 FAX: 610-545-6030

☐ **Factor Support Network**
TEL: 877-376-4968 FAX: 805-482-6324

☐ **Matrix Health**
TEL: 877-337-3002 FAX: 888-385-2805

☐ **Med Center Specialty Pharmacy**
TEL: 855-633-5633 FAX: 304-344-0655

☐ **MedEx BioCare**
TEL: 800-962-6339 FAX: 901-382-3091

Patient Name _____ SS# _____ DOB _____ ☐ Male ☐ Female
Street Address _____ Apt# _____ City _____ State _____ Zip _____
Daytime Tel _____ Cell _____ Email _____ Height _____ Weight _____ BSA _____
Ship to Patient at ☐ Home ☐ Work OR Patient will pick up at ☐ Physician Office Local Pharmacy Phone _____
Allergies _____ Comorbidities _____
Current Medications (if necessary, please fax a complete list) _____

PRACTICE NAME	ADDRESS	PHONE	PRIMARY CONTACT

PRESCRIBER INFORMATION (PLEASE INCLUDE PHYSICIAN NAME AND NPI#)

☐ _____ # _____ ☐ _____ # _____ ☐ _____ # _____
☐ _____ # _____ ☐ _____ # _____ ☐ _____ # _____
☐ _____ # _____ ☐ _____ # _____ ☐ _____ # _____

Insured's Name _____ Relation to Patient _____
Eligible for Medicare ☐ Yes ☐ No If yes, Medicare# _____ Prescription Card ☐ Yes ☐ No If Yes, Carrier _____
Tel _____ Fax _____ Policy/Group# _____
Bin# _____ Pcn# _____ RXID# _____ RX Group# _____

ICD-10 Diagnosis _____ PPD (TB Test) _____ Chest X-ray _____
Date of Labs _____ Rheumatoid Factor Positive _____ Total Swollen Joints _____

☐ To my knowledge, patient has not previously been treated with a biologic/systemic agent for the diagnosed condition. If previously treated:
Is there a contraindication/intolerance/allergy to Cosentyx, Enbrel, Humira, Otezla, Remicade, Stelara, other biologic/systemic treatment?
☐ Methotrexate ☐ Cosentyx ☐ Enbrel ☐ Humira ☐ Otezla ☐ Remicade ☐ Stelara ☐ Other _____ ☐ No
Is there documented failure of adequate trial on any of these medications?
☐ Methotrexate ☐ Cosentyx ☐ Enbrel ☐ Humira ☐ Otezla ☐ Remicade ☐ Stelara ☐ Other _____ ☐ No

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

TALTZ 80mg/mL *PSORIATIC ARTHRITIS* ☐ Autoinjector ☐ Prefilled Syringe
Start Dose: ☐ Inject 160 mg subcutaneously at week 0 QTY: 2 Refill:____
Maintenance: ☐ Inject 80mg subcutaneously every 4 weeks QTY:_____ Refills: _____

KEVZARA® (sarilumab)
Dose: ☐ 200 mg/1.14 mL PFS ☐ 150 mg/1.14 mL PFS
Dispense: ☐ Inject 150 mg subcutaneously every other week QTY: 2 Refills: _____
☐ Inject 200 mg subcutaneously every other week QTY: 2 Refills: _____

CIMZIA® (certolizumab pegol)
Initial Dose: ☐ 400mg (two 200mg subcutaneous injections) at weeks 0, 2 & 4 (Starter Kit #6)
Maintenance Dose: ☐ 200mg subcutaneous injection every other week
☐ Other _____ QTY:_____ Refills: _____

☐ **HUMIRA®** (adalimumab) ☐ **HUMIRA Citrate-Free** Patient wt (kg) _____
Dose ☐ 40mg/0.8mL PFS ☐ 40mg/0.8mL Pens ☐ 20mg/0.4mL PFS
Dispense: ☐ Inject 40mg subcutaneously every other week QTY_____ Refills _____
Juvenile Arthritis
☐ Patient weight 15kg to < 30kg inject 20mg subcutaneously every other week
☐ Patient weight > 30kg inject 40mg subcutaneously every other week

REMICADE 100 mg vial ☐ MD Office Infusion ☐ Home Infusion
Infusion Supplies: ☐ YES ☐ NO
☐ **Starting Dose:** ____mg/kg ____mg on week 0, week 2 & week 6 then,
☐ **Maintenance Dose:** ____mg/kg _____ mg every 8 weeks for ____ infusions every 8 weeks
☐ Other _____ QTY_____ Refills _____

STELARA
Starting Dose: ☐ 45mg ☐ 90mg subcutaneously initially & 4 weeks later QTY: 2
Maintenance Dose: ☐ 45mg ☐ 90mg subcutaneously every 12 weeks
QTY:_____ Refills _____

☐ **ACTEMRA®** (tocilizumab) Vials Patient wt (kg) _____
☐ 80mg/4ml ☐ 200mg/10ml ☐ 400mg/20ml
Sig: _____
QTY_____ Refills _____

☐ **ACTEMRA®** (tocilizumab) PFS
Inject 162mg (1 syringe) subcutaneously:
☐ every other week (pt wt<100kg) QTY:_____ Refills: _____
☐ every week (pt wt >100kg or per clinical response) QTY:_____ Refills: _____

OLUMIANT (baricitinib)
SIG: ☐ 2mg PO once daily with or without food QTY: 30 Refills: _____

SIMPONI® (golimumab) Dose: *SmartJect*™ ☐ 50mg/0.5mL | Prefilled Syringe ☐ 50mg/0.5mL
SIG: inject 50mg subcutaneously once per month QTY: _____ Refills: _____

SIMPONI ARIA® ☐ 50mg/4mL vial QTY: _____ (vials) Refills: _____
Infuse _____mg (2mg/kg) IV over 30 minutes at weeks 0 and 4, then every 8 weeks

FORTEO® ☐ Pen (#1 pen) SIG: ☐ Inject 20mcg subcutaneous daily Refills: _____
☐ Pen Needles 31G 3/16" QTY: 1 Box Refills: _____

KINERET® (anakinra) SIG: ☐ Inject _____ mg subcutaneously every day
QTY: _____ Refills: _____

ORENCIA® SIG: ☐ Inject 125mg subcutaneously weekly QTY: 28 day Refills: _____
SIG: ☐ 250mg Vial (IV use only) Loading Dose: 10mg/kg IV x 1 dose,
then 125mg subcutaneous weekly, start within 24hrs of IV dose, 1 dose, 4 week supply

XELJANZ® (tofacitinib citrate) ☐ 5mg tablet **XELJANZ XR®** (tofacitinib citrate) ☐ 11mg tablet
SIG: Take ☐ 5mg tablet by mouth twice daily **OR** ☐ 11mg tablet by mouth once daily
QTY: _____ Refills: _____

ENBREL® **Dose:** PFS ☐ 25mg ☐ 50mg | Multiuse Vial ☐ 25mg
SureClick™ ☐ 50mg | Enbrel Mini™/AutoTouch ☐ 50mg
Dispense: ☐ 1x week ☐ 2x week QTY: _____ Refills: _____

OTEZLA® ☐ 28 day Titration Starter Pack ☐ Tablets
☐ Take as directed *These directions can only be selected for the Titration Starter Pack*
QTY 55 Refills ____
☐ Take 30 mg once daily QTY: 30 Refills: _____
☐ Take 30 mg twice daily QTY: 60 Refills: _____

COSENTYX
Starter Dose: ☐ Sensoready® Pen ☐ Prefilled Syringe
SIG: ☐ Inject 150 mg dose subcutaneous once weekly for Weeks 0, 1, 2, 3, and 4
QTY: _____ Refills: _____
Maintenance Supply: ☐ Sensoready® Pen ☐ Prefilled Syringe
SIG: ☐ Inject 150 mg dose subcutaneous once every 4 weeks QTY: _____ Refills: _____

OTHER _____
SIG: _____ QTY: _____ Refills: _____

By signing this form and utilizing our services, you are authorizing BioMatrix Specialty Pharmacy, its subsidiaries and their employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature (signature required. NO STAMPS) _____ *Dispense as written* **Date** _____

Prescriber's Signature (signature required. NO STAMPS) _____ *Product Substitution Permitted* **Date** _____