



# RA & INFLAMMATION REFERRAL FORM

210 Rock Road | Glen Rock, NJ 07452  
TEL: 201-444-3200 | FAX: 201-444-5792  
Toll Free: 866-888-3200

Today's Date

CURRENT PATIENT  
 NEW PATIENT

July 2017

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	PRACTICE ADDRESS	CONTACT INFORMATION	LICENSE INFORMATION

REFERRAL SOURCE INFORMATION					
<input type="checkbox"/>		#		<input type="checkbox"/>	
<input type="checkbox"/>		#		<input type="checkbox"/>	
<input type="checkbox"/>		#		<input type="checkbox"/>	
<input type="checkbox"/>		#		<input type="checkbox"/>	
<input type="checkbox"/>		#		<input type="checkbox"/>	

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 \_\_\_\_\_  
Previously treated?  Yes  No If yes, what drugs \_\_\_\_\_

## PRESCRIPTION PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

**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 SQ injections) at weeks 0, 2 & 4 (Starter Kit #6)  
Maintenance Dose:  200mg SQ injection every other week  
 Other \_\_\_\_\_ QTY \_\_\_\_\_ Refills \_\_\_\_\_

**ENBREL®** (etanercept)  
Dose: PFS  25mg  50mg | Multiuse Vial  25mg | SureClick™  50mg  
Dispense:  1x week  2x week QTY \_\_\_\_\_ Refills \_\_\_\_\_

**HUMIRA®** (adalimumab) 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 SQ every other week  
 Patient weight > 30kg inject 40mg SQ 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 SQ initially & 4 weeks later QTY: 2  
Maintenance Dose:  45mg  90mg SQ 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)  
 every week (pt wt > 100kg or per clinical response)  
QTY \_\_\_\_\_ Refills \_\_\_\_\_

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

**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)  Inject 20mcg SQ Daily Refills \_\_\_\_\_  
 Pen Needles 31G 3/16" Qty: 1 Box Refills \_\_\_\_\_

**KINERET®** (anakinra)  Inject \_\_\_\_\_ mg SQ every day Qty \_\_\_\_\_ Refills \_\_\_\_\_

**ORENCIA®**  Inject 125mg subcutaneously weekly Qty 28 day Refills \_\_\_\_\_  
 250mg Vial (IV use only) Loading Dose: 10mg/kg IV x 1 dose, then 125mg SC weekly, start within 24hrs of IV dose, 1 dose, 4 week supply

**XELJANZ®** (tofacitinib citrate)  
 5mg tablet Sig: take one tablet by mouth twice daily QTY \_\_\_\_\_ Refills \_\_\_\_\_

**XELJANZ XR®** (tofacitinib citrate)  
 11mg tablet Sig: take one tablet by mouth daily 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 SQ once weekly for Weeks 0, 1, 2, 3, and 4  
QTY: \_\_\_\_\_ Refills: \_\_\_\_\_  
Maintenance Supply  Sensoready® Pen  Prefilled Syringe  
SIG:  Inject 150 mg dose SQ once every 4 weeks  
QTY: \_\_\_\_\_ Refills: \_\_\_\_\_

**OTHER** \_\_\_\_\_  
Sig \_\_\_\_\_ Qty \_\_\_\_\_ Refills \_\_\_\_\_

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

**Prescriber's Signature** (signature required, NO STAMPS) \_\_\_\_\_ **Date** \_\_\_\_\_

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.

Please fax completed referral form to **Glen Rock Medical Pharmacy** at 201-444-5792 Visit [www.GLENROCKMEDICALPHARMACY.com](http://www.GLENROCKMEDICALPHARMACY.com) for online fillable forms.



# NEW REFERRAL CHECKLIST

## PLEASE USE THIS CHECKLIST FOR PATIENTS WITH RHEUMATOID ARTHRITIS

Please use the attached checklist as a reference in order to provide the proper documentation to process the required prior authorization for your patient's treatment.

All lab reports (or EMR) must contain the following information within the last 30 days.

***Please forward any updates to us you receive from the insurance company regarding approvals or denials***

### **REQUIRED INFORMATION:**

- Patient name
- Patient Demographics (Address, Phone Number, DOB, etc...)
- Medication list and allergies
- Insurance information with RX insurance. Please include copy of card.

If the only card included is a medical card, please include local pharmacy information.

- MD name/NPI/Office contact/Phone number
- Drug indicated with refills
- MD signature and date on referral form
- Recent TB test results and date
- Previous treatment
- Symptoms
- Clinical notes

*Fax the requested documentation to (201) 444-5792*  
*Toll Free: 1-866-888-3200 Direct Phone: (201) 444-3200*  
*[GlenRockMedicalPharmacy.com](http://GlenRockMedicalPharmacy.com)*



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