

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 QuickRx Specialty Pharmacy and it's 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.

Provider please fax completed referral form to **QuickRx Specialty Pharmacy** at **800-540-1852** Visit **www.QuickRxSpecialty.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 (800) 540-1852
Toll Free: 1-800-496-6111 Direct Phone: (347) 691-3494



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