Rheumatology Referral Form
Please fax to:
866.279.3315

Patient Name:	Primary Ins:
DOB: SSN:	BinRx/PCN#: ID#: Group#:
Address:	Secondary Ins:
City/ST/Zip:	Sex: ____ M ____ F Height: Weight:
Phone#: Emergency contact#	Allergies:
Diagnosis: ICD-10:	TB/PPD: ____ Positive ____ Negative Date:

Previous treatment with: ____ Sulfasalazine ____ Corticosteroid ____ Methotrexate ____ 5-ASA ____ 6-MP ____ NSAIDS ____ Azathioprine ____ Remicade ____ Other Biologics

Dates of Therapy:_____ Reason for Discontinuation:_____

ACTEMRA		
❒ vials ❒ PFS	❒ IV: Infuse_____mg via IV every 4 weeks ❒ Inject 162mg subq every OTHER week ❒ Inject 162mg subq EVERY week	_____QTY _____REFILLS
HUMIRA		
❒ 20mg PEN ❒ 40mg PEN ❒ 20mg PFS ❒ 40mg PFS	❒ Inject 20mg subq every OTHER week ❒ Inject 40mg subq every OTHER week ❒ Inject 40mg subq every week	_____QTY _____REFILLS
CIMZIA		
❒ Starter Kit	❒ Inject 400mg (2 PFS/Vials) subq at weeks 0, 2, and 4	_____QTY _____REFILLS
❒ 200mg PFS ❒ 200mg Lyo Powder Vial	❒ Inject 200 mg (1 PFS/Vials) subq every other week ❒ Inject 400 mg (2 PFS/Vials) subq every 4 weeks	_____QTY _____REFILLS
STELARA		
❒ 45mg PFS ❒ 90mg PFS	❒ Inject 45mg subq on day 0 and day 28 ❒ Inject 90mg subq on day 0 and day 28	_____QTY _____REFILLS
ENBREL		
❒ 25mg PFS ❒ 50mg Sureclick ❒ 25mg vial ❒ 50mg PFS	❒ Inject 50mg subq twice weekly for 3 months ❒ Inject 50mg subq once weekly ❒ Inject 25mg subq once weekly	_____QTY _____REFILLS
SIMPONI		
❒ 50mg Smartject ❒ 50mg PFS	❒ Inject 50mg subq once a month	_____QTY _____REFILLS
XELJANZ		
❒ 11mg tablet - XR ❒ 5mg tablet	❒ Take 11mg by mouth once daily - XR ❒ Take 5mg by mouth twice daily	_____QTY _____REFILLS
ORENCIA		
❒ 125mg/ml PFS ❒125mg/ml Clickjet	❒ Inject 125mg subq once weekly	_____QTY _____REFILLS
OTEZLA		
❒ Titration Starter Kit	**Initial Dose**: Titration dose	__1__QTY __0__REFILLS
❒ 30mg tablet	**Maintenance Dose:** Take 30mg by mouth twice daily	_____QTY _____REFILLS
DMARDS		
❒ Otrexup	❒ Inject _____mg subq once a week	_____QTY _____REFILLS
❒ Rasuvo	❒ Inject _____mg subq once a week	_____QTY _____REFILLS
COSENTYX		
❒ 150 mg PFS ❒ 150 mg Sensoready PEN	**Initial Dose**: ❒ 150 mg subq at Weeks 0, 1, 2, 3, and 4 and every 4 weeks after ❒ 300 mg subq at Weeks 0, 1, 2, 3, and 4	❒ __5__QTY __0__REFILLS ❒ _10_QTY __0__REFILLS
	Maintenance Dose: ❒ 150 mg every 4 weeks ❒ 300 mg every 4 weeks	_____QTY _____REFILLS
KEVZARA		
❒ 200mg/ml ❒ 150mg/ml	❒ Inject 200mg subq once every 2 weeks ❒ Inject 150mg subq once every 2 weeks	____QTY ____REFILLS

Deliver to: ____ Patient's home ____ MD's Office ____ First dose to MD **Training:** ____ AbbVie ____ Cimplicity ____ Physician in office

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

Physician's Signature DAW **Substitution Allowed** **Date**

Physician Name:	Office Contact:	
Address:	Phone:	Fax:
City/St/Zip:	NPI:	DEA: