

<b>Rheumatology Referral Form</b>	<b>Century Specialty Script</b> <b>Fax Referral To: 877-521-5353</b> <b>Phone: 800-521-3949</b>	
Date: _____		

Patient Information	Prescriber Information
Patient Name: _____	Prescriber Name: _____
Address: _____	Address: _____
City, State, Zip: _____	City, State, Zip: _____
Home Phone: _____	Phone: _____
Cell Phone: _____	Fax: _____
DOB: _____	DEA: _____ NPI #: _____
Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Contact Person: _____

Insurance Information		
Primary Insurance: _____	ID#: _____	Group: _____
Secondary Insurance: _____	ID#: _____	Group: _____
Prescription Card: _____	ID#: _____ BIN#: _____ PCN#: _____	Group: _____


Clinical Information (Please fax all pertinent clinical and lab information)
<input type="checkbox"/> M06.9 (Rheumatoid Arthritis) <input type="checkbox"/> M08.0 (Juvenile Idiopathic Arthritis) <input type="checkbox"/> L40.59 (Psoriatic Arthritis) <input type="checkbox"/> L40.54 (Psoriatic Juvenile Arthritis) <input type="checkbox"/> M45.9 (Ankylosing Spondylitis) <input type="checkbox"/> M32.9 (Systemic Lupus Erythematosus) <input type="checkbox"/> Other: _____ Diagnosis Date: _____

Diagnosis and Clinical Assessment (Fill in below or attach lab work)
Joints Affected: _____ Number of Tender Joints: _____ CRP: _____ Date: _____ Number of Swollen Joints: _____ Current Weight: _____ Current Height: _____ Date: _____ ESR: _____ Date: _____ <input type="checkbox"/> New Therapy Induction   Stop Date: _____ <input type="checkbox"/> Therapy Change   Stop Date: _____ <input type="checkbox"/> Therapy Continuation   Stop Date: _____ <input type="checkbox"/> Weeks Completed: <input type="checkbox"/> 0 <input type="checkbox"/> 2 <input type="checkbox"/> 4 <input type="checkbox"/> 6 Allergies: _____ TB Results & Date (Please provide copy of result): _____ <input type="checkbox"/> Bone Density Score & Date (Please provide a copy of results): _____

Medication	Dose Strength	Directions	Qty	Refills
Actemra	<input type="checkbox"/> Prefilled Syringe 162mg/0.9mL <input type="checkbox"/> Auto Injector 162mg/0.9mL	<input type="checkbox"/> <100kg Inject 162mg/0.9mL SC every 2 weeks <input type="checkbox"/> >100kg Inject 162mg/0.9mL SC every week		
Benlysta	<input type="checkbox"/> 10mg/kg <input type="checkbox"/> 200mg PFS <input type="checkbox"/> 200mg Autoinjector	<input type="checkbox"/> <b>IV Starter Dose:</b> Infuse 10mg/kg every 2 weeks for 3 doses <input type="checkbox"/> <b>IV Maintenance:</b> Inject 10mg/kg every 4 weeks <input type="checkbox"/> Inject 200mg SC once weekly (if switching from IV administer first SC dose 1-4 weeks after last IV dose)		
Cimzia	<input type="checkbox"/> Starter Kit <input type="checkbox"/> Syringe <input type="checkbox"/> Vial	<input type="checkbox"/> <b>Starter Dose:</b> Inject 400mg SC on week 0, 2, and 4 <input type="checkbox"/> <b>Maintenance Dose:</b> Inject 200mg SC every 2 weeks <input type="checkbox"/> <b>Maintenance Dose:</b> Inject 400mg SC once a month		
Cosentyx	<input type="checkbox"/> 150mg Sensoready Pen <input type="checkbox"/> 300mg Sensoready Pen	<input type="checkbox"/> <b>Starter Dose:</b> Inject 150mg SC on week 0, 1, 2, 3, and 4 <input type="checkbox"/> <b>Maintenance:</b> Inject 150mg SC every 4 weeks <input type="checkbox"/> <b>Starter Dose:</b> Inject 300mg SC on week 0, 1, 2, 3, and 4 <input type="checkbox"/> <b>Maintenance:</b> Inject 300mg SC every 4 weeks	<input type="checkbox"/> 5 <input type="checkbox"/> 1 <input type="checkbox"/> 10 <input type="checkbox"/> 2	
Enbrel	<input type="checkbox"/> 25mg Syringe <input type="checkbox"/> 0.25mg Vial <input type="checkbox"/> 50mg Syringe <input type="checkbox"/> 50mg SureClick Pen <input type="checkbox"/> Mini 50mg/mL	<input type="checkbox"/> Inject 50mg SC every week <input type="checkbox"/> Inject _____mg(0.8mg/kg x _____kg) SC every week		
Evenity	<input type="checkbox"/> 105mg/1.17mL	<input type="checkbox"/> Inject 2 syringes (105mg each) for total dose of 210mg SQ once monthly	<input type="checkbox"/> 2	
Forteo	<input type="checkbox"/> 600mcg/2.4mL PFS	<input type="checkbox"/> <b>Maintenance:</b> Inject 20mcg SC once daily	<input type="checkbox"/> 1	
<input type="checkbox"/> Humira <input type="checkbox"/> Adalimumab (biosimilar)	<input type="checkbox"/> 10mg Syringe <input type="checkbox"/> 20mg Syringe <input type="checkbox"/> 40mg/0.4mL Syringe <input type="checkbox"/> 40mg/0.4mL Pen	<input type="checkbox"/> Inject 10mg SC every other week (10 to <15kg) <input type="checkbox"/> Inject 20mg SC every other week (15 to <30kg) <input type="checkbox"/> Inject 40mg SC every other week (30kg) <input type="checkbox"/> Inject 40mg SC once weekly		

Prescriber Signature: _____	DAW (Dispense as Written) Date: _____
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*The information contained in this facsimile may be confidential and is intended solely for the use of the named recipient(s). Access, copying or re-use of the facsimile or any information contained therein by any other person is not authorized. If you are not the intend recipient, please notify us immediately.*

<b>Rheumatology Referral Form</b>	<b>Century Specialty Script</b> <b>Fax Referral To: 877-521-5353</b> <b>Phone: 800-521-3949</b>	
Date: _____		

<b>Patient Information</b>	<b>Prescriber Information</b>
Patient Name: _____	Prescriber Name: _____
Address: _____	Address: _____
City, State, Zip: _____	City, State, Zip: _____
Home Phone: _____	Phone: _____
Cell Phone: _____	Fax: _____
DOB: _____	DEA: _____ NPI #: _____
Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Contact Person: _____

Insurance Information		
Primary Insurance: _____	ID#: _____	Group: _____
Secondary Insurance: _____	ID#: _____	Group: _____
Prescription Card: _____	ID#: _____	BIN#: _____ PCN#: _____ Group: _____

Clinical Information (Please fax all pertinent clinical and lab information)
<input type="checkbox"/> M06.9 (Rheumatoid Arthritis) <input type="checkbox"/> M08.0 (Juvenile Idiopathic Arthritis) <input type="checkbox"/> L40.59 (Psoriatic Arthritis) <input type="checkbox"/> L40.54 (Psoriatic Juvenile Arthritis) <input type="checkbox"/> M45.9 (Ankylosing Spondylitis) <input type="checkbox"/> M32.9 (Systemic Lupus Erythematosus) <input type="checkbox"/> Other: _____ Diagnosis Date: _____

Diagnosis and Clinical Assessment (Fill in below or attach lab work)
Joints Affected: _____ Number of Tender Joints: _____ CRP: _____ Date: _____ Number of Swollen Joints: _____ Current Weight: _____ Current Height: _____ Date: _____ ESR: _____ Date: _____ <input type="checkbox"/> New Therapy Induction   Stop Date: _____ <input type="checkbox"/> Therapy Change   Stop Date: _____ <input type="checkbox"/> Therapy Continuation   Stop Date: _____ <input type="checkbox"/> Weeks Completed: <input type="checkbox"/> 0 <input type="checkbox"/> 2 <input type="checkbox"/> 4 <input type="checkbox"/> 6 Allergies: _____ TB Results & Date (Please provide copy of result): _____ <input type="checkbox"/> Bone Density Score & Date (Please provide a copy of results): _____

Medication	Dose Strength	Directions	Qty	Refills
Kevzara	<input type="checkbox"/> 150mg/1.14mL PFS <input type="checkbox"/> 200mg/1.14mL Pen	<input type="checkbox"/> Inject 200mg SC once every 2 weeks <input type="checkbox"/> Other: _____		
Krystexxa	<input type="checkbox"/> 8mg/mL	<input type="checkbox"/> Infuse 8mg in 250mL of NS over 120 minutes once every 2 weeks		
Olumiant	<input type="checkbox"/> 2mg Tablet <input type="checkbox"/> 1mg Tablet	<input type="checkbox"/> Take one tablet PO daily		
Orencia	<input type="checkbox"/> 125mg Pen <input type="checkbox"/> 250mg Vial <input type="checkbox"/> 125mg Pen Syringe	<input type="checkbox"/> <b>IV Dosage:</b> Infuse _____ mg at weeks 0, 2, 4 then every 4 weeks thereafter <input type="checkbox"/> <b>SC Dosage:</b> Inject 125mg SC once a week		
Otezla	<input type="checkbox"/> Starter Pack <input type="checkbox"/> 30mg Tablet	<input type="checkbox"/> <b>Starter Pack:</b> Use as directed <input type="checkbox"/> <b>Maintenance Dose:</b> Take one tablet PO BID		
Prolia	<input type="checkbox"/> 60mg PFS	<input type="checkbox"/> Inject 1 syringe SC every 6 months		
<input type="checkbox"/> Avsola <input type="checkbox"/> Inflectra <input type="checkbox"/> Remicade <input type="checkbox"/> Renflexis	<input type="checkbox"/> 100mg Vial	<input type="checkbox"/> <b>Loading Dose:</b> Infuse 5mg/kg at weeks 0, 2, & 6 <input type="checkbox"/> <b>Maintenance Dose:</b> Infuse 5mg/kg every 8 weeks		
Rinvoq	<input type="checkbox"/> 15mg	<input type="checkbox"/> Take 1 tablet PO daily		
<input type="checkbox"/> Rituxan <input type="checkbox"/> Truxima	<input type="checkbox"/> 100mg Vial <input type="checkbox"/> 500mg Vial	<input type="checkbox"/> Infuse 1000mg on day 1 and day 15		

Prescriber Signature: _____	DAW (Dispense as Written) Date: _____
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**Century Specialty Script**  
**Fax Referral To: 877-521-5353**  
**Phone: 800-521-3949**



Date: \_\_\_\_\_

**Patient Information**

Patient Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_  
 Cell Phone: \_\_\_\_\_  
 DOB: \_\_\_\_\_  
 Gender:  M  F

**Prescriber Information**

Prescriber Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_  
 Fax: \_\_\_\_\_  
 DEA: \_\_\_\_\_ NPI #: \_\_\_\_\_  
 Contact Person: \_\_\_\_\_

**Insurance Information**

Primary Insurance: \_\_\_\_\_ ID#: \_\_\_\_\_ Group: \_\_\_\_\_  
 Secondary Insurance: \_\_\_\_\_ ID#: \_\_\_\_\_ Group: \_\_\_\_\_  
 Prescription Card: \_\_\_\_\_ ID#: \_\_\_\_\_ BIN#: \_\_\_\_\_ PCN#: \_\_\_\_\_ Group: \_\_\_\_\_

**Clinical Information (Please fax all pertinent clinical and lab information)**

M06.9 (Rheumatoid Arthritis)  M08.0 (Juvenile Idiopathic Arthritis)  L40.59 (Psoriatic Arthritis)  L40.54 (Psoriatic Juvenile Arthritis)  
 M45.9 (Ankylosing Spondylitis)  M32.9 (Systemic Lupus Erythematosus)  Other: \_\_\_\_\_  
 Diagnosis Date: \_\_\_\_\_

**Diagnosis and Clinical Assessment (Fill in below or attach lab work)**

Joints Affected: \_\_\_\_\_ Number of Tender Joints: \_\_\_\_\_ CRP: \_\_\_\_\_ Date: \_\_\_\_\_  
 Number of Swollen Joints: \_\_\_\_\_ Current Weight: \_\_\_\_\_ Current Height: \_\_\_\_\_ Date: \_\_\_\_\_ ESR: \_\_\_\_\_ Date: \_\_\_\_\_  
 New Therapy Induction | Stop Date: \_\_\_\_\_  Therapy Change | Stop Date: \_\_\_\_\_  
 Therapy Continuation | Stop Date: \_\_\_\_\_  Weeks Completed:  0  2  4  6  
 Allergies: \_\_\_\_\_  
 TB Results & Date (Please provide copy of result): \_\_\_\_\_  
 Bone Density Score & Date (Please provide a copy of results): \_\_\_\_\_

Medication	Dose Strength	Directions	Qty	Refills
Simponi/Simponi Aria	<b>Simponi:</b> <input type="checkbox"/> SmartJect 50mg/0.5mL <input type="checkbox"/> 50mg/0.5mL PFS <b>Simponi Aria:</b> <input type="checkbox"/> 50mg/4mL Vial	<b>Simponi:</b> <input type="checkbox"/> Inject 50mg SC once per month <b>Simponi Aria:</b> <input type="checkbox"/> Infuse _____ mg(2mg/kg) IV over 30 minutes at 0 and 4 weeks, then every 8 weeks		
Stelara	<input type="checkbox"/> 45mg/0.5mL PFS <input type="checkbox"/> 90mg/mL PFS	<input type="checkbox"/> Inject 45mg SC on Day 1 (<100kg) <input type="checkbox"/> Inject 90mg SC on day 1 (>100kg) <input type="checkbox"/> Inject 45mg SC on Day 29 and every 12 weeks thereafter (<100kg) <input type="checkbox"/> Inject 90mg SC on Day 29 and every 12 weeks thereafter (>100kg)		
Skyrizi	<input type="checkbox"/> 150 mg/mL in each single-dose prefilled pen <input type="checkbox"/> 90 mg/mL in each single-dose prefilled syringe <input type="checkbox"/> 150 mg/mL in each single-dose prefilled syringe	<input type="checkbox"/> <b>Initial Dose:</b> Inject 150mg SC weeks 0, and 4 <input type="checkbox"/> <b>Maintenance Dose:</b> Inject 150mg SC every 12 weeks		
Taltz	<input type="checkbox"/> 80mg/mL Autoinjector	<input type="checkbox"/> <b>Starter Dose:</b> Inject 160mg SC on Day 1 <input type="checkbox"/> <b>Maintenance:</b> Inject 80mg SC every 4 weeks		
Tremfya	<input type="checkbox"/> 100mg PFS <input type="checkbox"/> 100mg One-Press autoinjector	<input type="checkbox"/> Inject SubQ 100 mg at weeks 0, 4, and then every 8 weeks thereafter.		
Tymlos	<input type="checkbox"/> 80mcg/0.04mL	<input type="checkbox"/> Inject 80mcg SC once daily into periumbilical region; give with supplemental calcium and vitamin D if dietary intake is not adequate	<input type="checkbox"/> 1-Prefilled Pen	
Xeljanz/XR	<b>Xeljanz:</b> <input type="checkbox"/> 5mg Tablet <b>Xeljanz XR:</b> <input type="checkbox"/> 11mg Tablet	<b>Xeljanz:</b> <input type="checkbox"/> Take one tablet twice daily <b>Xeljanz XR:</b> <input type="checkbox"/> Take one tablet once daily	<input type="checkbox"/> 60 <input type="checkbox"/> 30	

Prescriber Signature: \_\_\_\_\_ DAW (Dispense as Written) Date: \_\_\_\_\_