# RHEUMATOLOGY REFERRAL FORM

Date: _____
☐ Current Patient ☐ New Patient

**Century Specialty Script**

**Fax Referral To: 877-521-5353**

**Phone: 800-521-3949**

Needs by Date: _____ Ship to ☐ Patient's Home ☐ Prescriber 1st Order Only ☐ Prescriber All Orders

## PATIENT INFORMATION

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____ Cell Phone: _____
Date of Birth: _____ Gender: ☐ M ☐ F

## PRESCRIBER INFORMATION

Prescriber Name/Contact: _____
Address: _____
City, State, Zip: _____
Phone: _____ Fax: _____
DEA#: _____ NPI#: _____

## INSURANCE INFORMATION *(Please attach the front and back of insurance and prescription drug card)*

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

## DIAGNOSIS & CLINICAL ASSESSMENT *(Fill in below or attach lab work)*

**Primary Diagnosis Code & Condition**: _____ **Joints Affected**: _____

**Number of Tender Joints**: _____ **Number of Swollen Joints**: _____ **Current Weight**: _____ **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)

## 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) ☐ _____ Diagnosis Date: _____

| Medication | Dose/Strength | Directions | Quantity | Refills |
|---|---|---|---|---|
| **Cimzia** | ☐ 2 X 200mg Kit ☐ Syringe ☐ Vial | **SIG:** ☐ Inject 200mg SC every 2 weeks | | |
| **Cosentyx** | ☐ Sensoready Pen ☐ Pre-filled syringe | ☐ **Starter Dose**: Inject 150 mg SQ on week 0, 1, 2, 3 and 4(Qty 5)<br>☐ **Maintenance**: Inject 150 mg SQ every 4 weeks(Qty 1)<br>☐ **Starter Dose:** Inject 300 mg SQ on week 0, 1, 2, 3 and 4(Qty 10)<br>☐ **Maintenance:** Inject 300 mg SQ every 4 weeks(Qty 2) | | |
| **Enbrel** | ☐ 25mg Syringe ☐ 25mg Vial<br>☐ 50mg Syringe ☐ 50mg SureClick Pen<br>☐ Mini 50mg/ml | **SIG:** ☐ Inject 50mg SC every week<br>☐ Inject _____mg (0.8mg/kg x ___kg) SC every week | | |
| **Forteo** | ☐ 600mcg/2.4ml PFS | **Maintenance:** ☐ Inject 20mcg SC once daily | 4 week supply | |
| **Humira** | ☐ 10mg Syringe ☐ 20mg Syringe<br>☐ 40mg/0.4ml Syringe ☐ 40mg/0.4ml Pen | **SIG:** ☐ Inject 10mg SC every other week (10 to <15 kg)<br>☐ Inject 20mg SC every other week (15 to <30 kg)<br>☐ Inject 40mg SC every other week (≥ 30 kg)<br>☐ Inject 40mg SC once weekly | | |
| **Olumiant** | ☐ 2mg Tablet | **Maintenance:** ☐ Take one tab PO daily | | |
| **Kevzara** | ☐ 150mg/1.14ml PFS ☐ 200mg/1.14 PFS<br>☐ 200mg | **SIG:** ☐ Inject 200mg sc once every 2 weeks<br>☐ Other:_____ | | |
| **Orencia** | ☐ (4) 125 mg Pen ☐ 250mg Vial<br>☐ 125mg syringe | **SIG:** ☐ IV Dosage: Infuse _____mg at weeks 0, 2, 4 then every 4 weeks thereafter<br>☐ SC dosage: Inject 125mg SC once a week | | |
| **Otezla** | ☐ Starter Pack ☐ 30mg Tablet | **SIG:** ☐ Starter Pack - Use as directed<br>☐ Maintenance Dose - Take one tablet PO BID | | |
| **Prolia** | ☐ 60mg PFS | ☐ Inject 1 syringe SC every 6 months<br>☐ Bone Density Score:_____ Date:_____ | | |
| **Remicade/Inflectra/ Renflexis** | ☐ 100 mg Vial | **SIG:** ☐ IV____mg at weeks 0, 2, 6 weeks(induction)<br>☐ IV ____mg every 8 weeks(maintenance)<br>☐ IV ____mg every _____ weeks | | |
| **Rinvoq** | ☐ 15 mg | ☐ Take 1 tablet po daily | | |
| **Rituxan** | ☐ 100 mg Vial ☐ 500mg Vial | **Starter Dose:** ☐ Infuse 1000mg on day 1 and day 15<br>**Maintenance:** ☐ Infuse 1000mg every 16 to 24 weeks thereafter | | |
| **Simponi/Simponi Aria** | **Simponi**:<br>☐ SmartJect 50mg/0.5ml ☐ PFS 50mg/0.5ml<br>**Simponi Aria:**<br>☐ 50mg/4ml Vial | **Simponi:**<br>☐ Inject 50mg sc once per month<br>**Simponi Aria:**<br>☐ Infuse ____mg(2mg/kg) IV over 30 minutes at 0 and 4, then every 8 weeks | | |
| **Stelara** | ☐ 1 X 45 mg/0.5 mL PFS<br>☐ 1 X 90 mg/mL PFS | ☐ Inject 45mg SC on Day 1 (<100kg)<br>☐ Inject 90mg SC on Day 1 (>100kg)<br>☐ Inject 45 mg SC on Day 29 and every 12 weeks thereafter (<100kg)<br>☐ Inject 90 SC on Day 29 and every 12 weeks thereafter (>100kg) | | |
| **Taltz** | ☐ 80 mg/ml Autoinjector | ☐ **Starter Dose:** Inject 160 mg SC on day 1<br>☐ **Maintenance:** Inject 80mg SC every 4 weeks | | |
| **Tymlos** | ☐ 3120mg/1.56ml | **SIG:** ☐ 80mcg SC once daily into periumbilical region; give with supplemental calcium and vitamin D if dietary intake is not adequate | 1 pre-filled pen | |
| **Xeljanz/XR** | **Xeljanz:**<br>☐ 5mg Tablet<br>**Xeljanz XR**<br>☐ 11mg Tablet | **Xeljanz:**<br>SIG: ☐ Take 5mg po twice daily(Qty 60)<br>**Xeljanz XR:**<br>SIG: ☐ Take 11mg po once daily(Qty 30) | | |

If Century Specialty Script is the patient's choice, please Call, Fax, Mail, or send an electronic prescriptions to:
**Century Specialty Script, 6 Fisher Avenue, Tuckahoe, NY, 10707 • Phone (800) 521-3949, Fax (877) 521-5353**

**Prescriber Signature:** _____ **DAW (Dispense as Written)** ☐ Y ☐ N **Date:** _____