aleracare
advanced specialty pharmacy

Rheumatology
Referral Form

Patient Information			Prescriber Information	
Patient Name:	DOB:		Prescriber's Name:	
Address:			NPI#:	
City:	State:	Zip:	DEA#:	License#:
Phone:	Alternate Phone:	SSN:	Address:	
Height: Weight:	Allergies:		Phone:	Fax:
Emergency Contact:	Phone:		Contact Person:	

Client Consideration

Diagnosis: ◯ M06.9 Rheumatoid Arthritis ◯ L40.59 Psoriatic Arthritis ◯ M81.0 Osteoporosis ◯ M45.9 Ankylosing Spondylitis ◯ K50.00 Crohn's Disease
◯ Other:_____

Prior Failed Meds: ◯ Methotrexate Length of Treatment _____ Reason for Discontinuing _____
_____ Length of Treatment _____ Reason for Discontinuing _____
_____ Length of Treatment _____ Reason for Discontinuing _____

Forteo/Prolia: T-Score _____ Type _____ Date _____ **Fracture History:** Site _____ Date _____ Site _____ Date _____

Does patient have a latex allergy? ◯ Yes ◯ No TB/PPD Test given or intended to be given before start? ◯ Yes ◯ No

Medication			Qty	Refills
◯ **ACTEMRA®**	◯ 162mg/0.9ml Prefilled Syringe	◯ Inject 1 syringe SC ◯ Every Week ◯ Every Other Week		
◯ **CIMZIA® STARTER DOSE** ◯ **CIMZIA® MAINTENANCE**	◯ 200mg Starter Kit (contains 6, 200mg PFS) ◯ 2 x 200mg Prefilled Syringe	Starter: ◯ Inject 400mg SC once, then repeat at weeks 2 and 4 Maintenance: ◯ 200mg SC ONCE every TWO weeks ◯ 400mg SC ONCE every FOUR weeks		
◯ **COSENTYX® STARTER DOSE** ◯ **COSENTYX® MAINTENANCE**	◯ 150 mg/ml Sensoready Pen ◯ 150 mg/ml Pre-filled Syringe	◯ Starter: Inject 150mg SQ on week 0, 1, 2, 3, and 4 (Quantity: 5) ◯ Maintenance: Inject 150mg SQ every 4 weeks ◯ Starter: Inject 300 mg SQ on week 0, 1, 2, 3, and 4 (Quantity: 10) ◯ Maintenance: Inject 300mg SQ every 4 weeks		
◯ **ENBREL®**	◯ 50mg/ml SureClickTM Autoinjector ◯ 50mg/ml Prefilled Syringe ◯ 25mg/0.5ml Prefilled Syringe	◯ Inject 50mg SC ONCE a week ◯ Inject 25mg TWICE a week, 72 to 96 hours apart ◯ Other: _____		
◯ **FORTEO®**	◯ 600mcg/2.4ml PFS	◯ Inject 20mcg SC, as directed, once daily		
◯ **HUMIRA®**	◯ 40mg/0.8ml Pen ◯ 40mg/0.8ml Prefilled Syringe	◯ Inject 40mg SC every OTHER week ◯ Inject 40mg SC ONCE a week		
◯ **METHOTREXATE®**	◯ 2.5mg Tablets ◯ 25mg/ml Injectable Solution	◯ Take _____tablet(s) by mouth every week ◯ Inject _____ml SQ every 7 days at the same time each week		
◯ **ORENCIA®**	◯ 125mg/ml Prefilled Syringe (4 syringes)	◯ Inject 125mg SC ONCE Weekly		