LIFECARE PHARMACY

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Rheumatology Referral Form

Surescripts ID #:

Office #: 1-210-881-0890
Fax #: 1-210-569-6464

Referral Info

PATIENT INFORMATION

PATIENT NAME		SSN #:		DOB:	
ADDRESS:		CITY:	STATE:	ZIP:	
HOME PHONE:	CELL PHONE:	HEIGHT:	WEIGHT:	GENDER: MALE FEMALE	
Email ADDRESS:		DIAGNOSIS CODE:			

INSURANCE INFORMATION (or attach copy of your cards)

Primary Insurance Co:	Phone:	Policy#:	Group#:
Secondary Insurance Co:	Phone:	Policy#:	Group#:

PRESCRIPTION INFORMATION (For IV medications attach a copy of your prescription.)

To prevent generic substitution, Prescriber to handwrite "Brand Medically Necessary" and sign:

❑ ACTEMRA®	❑ INDUCTION	❑ MAINTENANCE
❑ COSENTYX®	❑ INDUCTION	❑ BRIDGE* ❑ MAINTENANCE
❑ CIMZIA®	❑ INDUCTION	❑ MAINTENANCE
❑ ENBREL®	❑ INDUCTION	❑ MAINTENANCE
❑ KEVZARA®	❑ INDUCTION	❑ MAINTENANCE
❑ HUMIRA® CITRATE-FREE	❑ STARTER PACK	❑ MAINTENANCE
❑ HUMIRA®	❑ STARTER PACK	❑ MAINTENANCE
❑ OTEZLA®	❑ TITRATION PACK	❑ BRIDGE ❑ MAINTENANCE
❑ TALTZ®	❑ INDUCTION	❑ MAINTENANCE
❑ SIMPONI®	❑ INDUCTION	❑ MAINTENANCE
❑ XELJANZ®	❑ INDUCTION	❑ MAINTENANCE
❑ OLUMIANT®	❑ INDUCTION	❑ MAINTENANCE

Primary Diagnosis

o Rheumatoid Arthritis o Psoriatic Arthritis
o Other: _____
o Osteoporosis o Forteo o Prolia
o Other _____

Prior Treatment

o Methotrexate o Duration _____
o Cyclosporine o Duration _____
o Sulfasalazine o Duration _____
o Other o Duration _____
OTB/PPD Test Negative? o Yes o No Date of Test: _____
Medical Justification for Prescribing Biologic Therapy (or attach history)
No response to previous treatment
(list): _____
Contraindications
(list): _____
Side effects, lab abnormalities, toxicity issues
(list): _____

▪ **OTHER**

INDUCTION STARTER	MAINTENANCE	STRENGTH:
STRENGTH:	**STRENGTH:**	**SIG/DIRECTIONS**
SIG/DIRECTIONS	**SIG/DIRECTIONS**	
o AUTOINJECTOR o PEN o PREFILLED SYRINGE o VIAL	o AUTOINJECTOR o PEN o PREFILLED SYRINGE o VIAL	
QUANTITY: **REFILLS:**	**QUANTITY:** **REFILLS:**	**QUANTITY:** **REFILLS:**

PHYSICIAN INFORMATION

Prescriber Name:	**Phone:**	**Fax:**
Office Contact/Faxed by:	**Email:**	
NPI#:	**TAXID#:**	**Ship To:** O **Patient** O **MD 1ST Fill Only** O **MD All Orders**
Prescriber Signature:		
○**Dispense as written**	**Date**	

Your signature authorizes the pharmacy to act on your behalf to obtain prior authorization for the prescribed medications. We will also pursue available copay and financial assistance on behalf of your patients.

* We will let you know within 2 hours if your patient can be admitted pending insurance Qualification or non-admitted and triaged to another pharmacy

This prescription is valid only if transmitted by Facsimile machine by a licensed prescriber

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