



# RA Referral Form

Phone: 1-888-315-3395  
Fax: 1-888-315-3270

Attn: \_\_\_\_\_

Need by Date: \_\_\_\_\_  
Ship To:  Patient  Physician\*  
 Nursing needed  Training needed

*\*If shipped to physician's office, physician accepts on behalf of patient for administration in office.*

## General Information

Patient Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Home Phone: _____ Work: _____ Cell Phone: _____ Language: _____ Soc. Sec #: _____ - _____ - _____ Date of Birth: _____ Allergies: _____ Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <b>Weight</b> _____ <b>Height</b> _____	Physician Name: _____ Practice Name/Hospital: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____ State Lic #: _____ DEA #: _____ NPI #: _____ Nurse/Key Office Contact: _____
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## Insurance Information

Primary Insurance: _____	Cardholder Name: _____	Secondary Insurance: _____
Employer: _____	ID#: _____	ID#: _____ Group#: _____
Phone: _____	Group#: _____	Phone: _____

## Diagnosis

Rheumatoid Arthritis (714.0)  
  Psoriatic Arthritis (696.0)  
  Osteoporosis (733.0)  
  Osteoarthritis (715.0)  
 Polyarticular Juvenile Rheumatoid Arthritis (714.30)  
 Ankylosing Spondylitis (720.0)  
 Other: \_\_\_\_\_ ICD 9 Code \_\_\_\_\_

## PRESCRIPTION ORDER (PLEASE CHECK ONE OR MORE)

<input type="checkbox"/> <b>Boniva</b> 3mg/3ml PFS SIG: 3mg IV over 15 to 30 seconds Q 3 months <i>(administered quarterly by a physician)</i> <b>Qty:</b> 1 Dose <b>Refill:</b>	<input type="checkbox"/> <b>Reclast</b> 5mg/100mL SIG: 5mg IV over 15 to 30 minutes once a year. <i>(administered annually by physician)</i> <b>Qty:</b> 1 dose <b>Refill:</b>	<input type="checkbox"/> <b>Rituxan</b> (MD's office infusion) SIG: 1000 mg IV infusion as directed on: <input type="checkbox"/> Day 1 <input type="checkbox"/> Day 15 <input type="checkbox"/> Day 1 & Day 15 <b>Qty:</b> <b>Dose(s)</b> <b>Refill:</b>												
<input type="checkbox"/> <b>Actemra</b> Weight: _____ <input type="checkbox"/> 80mg/4mL <input type="checkbox"/> 200mg/10mL <input type="checkbox"/> 400mg/20mL SIG: Infuse _____ IV over 1 hour every 4 weeks.  <i>Adults: 4 mg/kg IV given over 1 hour every 4 weeks. If needed, increase dose to 8 mg/kg IV every 4 weeks; doses &gt; 800 mg per infusion are not recommended.</i> <b>Qty:</b> 1 month <b>Refill:</b>	<input type="checkbox"/> <b>Orencia</b> 250mg Vial <i>(CIRCLE dosage based on patient's weight)</i> <table border="1" style="width:100%; border-collapse: collapse; margin: 5px 0;"> <thead> <tr> <th>Body Weight</th> <th>Dose</th> <th>Vials/dose</th> </tr> </thead> <tbody> <tr> <td>&lt;60 kg</td> <td>500 mg</td> <td>2</td> </tr> <tr> <td>60 - 100 kg</td> <td>750 mg</td> <td>3</td> </tr> <tr> <td>&gt;100 kg</td> <td>1000 mg</td> <td>4</td> </tr> </tbody> </table> SIG: <input type="checkbox"/> Infuse at 0, 2, 4 weeks, then every 4 weeks. <input type="checkbox"/> Every 4 weeks <b>Qty:</b> 1 month <b>Refill:</b>	Body Weight	Dose	Vials/dose	<60 kg	500 mg	2	60 - 100 kg	750 mg	3	>100 kg	1000 mg	4	<input type="checkbox"/> <b>Remicade</b> 100mg Vial      Weight: _____ SIG: <input type="checkbox"/> 3mg/kg IV at week 0, 2, and 6 wks, then q 8 wks <input type="checkbox"/> 5mg/kg IV at week 0, 2, and 6 wks, then q 8 wks <input type="checkbox"/> _____mg IV every _____ weeks <b>Qty:</b> 1 month <b>Refill:</b>
Body Weight	Dose	Vials/dose												
<60 kg	500 mg	2												
60 - 100 kg	750 mg	3												
>100 kg	1000 mg	4												
<input type="checkbox"/> <b>Humira</b> <input type="checkbox"/> PEN 40 mg <input type="checkbox"/> PFS 40 mg <input type="checkbox"/> PEN 20 mg (PEDIATRIC) SIG: <input type="checkbox"/> Inject 40mg SQ ONCE a week <input type="checkbox"/> Inject 40mg SQ EVERY 2 WEEKS <input type="checkbox"/> _____ <b>Qty:</b> 1 month <b>Refill:</b>	<input type="checkbox"/> <b>Cimzia</b> 200mg/ml PFS SIG: <input type="checkbox"/> 400 mg SQ week 0, 2 & 4, then q 4 weeks. <input type="checkbox"/> 400 mg SQ q 4 weeks. <input type="checkbox"/> _____ <b>Qty:</b> 1 month <b>Refill:</b>	<input type="checkbox"/> <b>Simponi</b> SIG: Inject 50 mg SQ once a month <b>Qty:</b> 1 dose <b>Refill:</b>												
<input type="checkbox"/> <b>Enbrel</b> <input type="checkbox"/> 25 mg vials <input type="checkbox"/> 25 mg PFS - 4/BOX <input type="checkbox"/> 50mg/ml Sureclick Pen <input type="checkbox"/> 50 mg/ml PFS SIG: <input type="checkbox"/> Inject _____mg SQ TWICE weekly <input type="checkbox"/> Inject _____mg SQ ONCE weekly. <input type="checkbox"/> Inject 50mg SQ TWICE weekly x 3 mos., then q weekly thereafter <input type="checkbox"/> _____ <b>Qty:</b> 1 month <b>Refill:</b>														

**Other:** \_\_\_\_\_      **SIG:** \_\_\_\_\_      **Qty:** \_\_\_\_\_      **Refills:** \_\_\_\_\_

\*If you would like brand name, please write Medically Necessary. Please note that Axium will dispense our formulary product unless otherwise specified. \* All the supplies including syringes and needles will be dispensed if needed.

**Physician Signature:** \_\_\_\_\_      **Date:** \_\_\_\_\_

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