MED CENTER SPECIALTY PHARMACY
A BIOMATRIX Company

RA & INFLAMMATION REFERRAL FORM

3100 MacCorkle Avenue S.E. | Suite 100
Charleston, WV 25304
TEL: 304-344-8021 | FAX: 304-344-0655

Today's Date

☐ CURRENT PATIENT
☐ NEW PATIENT

Feb 2018

Patient Name _____ SS#_____ DOB _____ ☐ Male ☐ Female
Street Address _____ Apt# _____ City _____ State _____ Zip _____
Daytime Tel _____ Cell _____ Email _____ Height _____ Weight _____ BSA _____
Ship to Patient at ☐ Home ☐ Work OR Patient will pick up at ☐ Physician Office Local Pharmacy Phone_____
Allergies _____ Comorbidities _____
Current Medications (if necessary, please fax a complete list) _____

PRACTICE NAME	PRACTICE ADDRESS	CONTACT INFORMATION	LICENSE INFORMATION

REFERRAL SOURCE INFORMATION

☐ _____ #_____	☐ _____ #_____	☐ _____ #_____
☐ _____ #_____	☐ _____ #_____	☐ _____ #_____
☐ _____ #_____	☐ _____ #_____	☐ _____ #_____
☐ _____ #_____	☐ _____ #_____	☐ _____ #_____
☐ _____ #_____	☐ _____ #_____	☐ _____ #_____

Insured's Name _____ Relation to Patient _____
Eligible for Medicare ☐ Yes ☐ No If yes, Medicare# _____ Prescription Card ☐ Yes ☐ No If Yes, Carrier _____
Tel _____ Fax _____ Policy/Group# _____
Bin# _____ Pcn# _____ RXID# _____ RX Group# _____

ICD-10 Diagnosis_____ PPD (TB Test)_____ Chest X-ray _____
Date of Labs_____ Rheumatoid Factor Positive _____ Total Swollen Joints _____
Previously treated? ☐ Yes ☐ No If yes, what drugs _____

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

TALTZ 80mg ☐ Autoinjector ☐ Prefilled Syringe
Psoriatic Arthritis Start Dose: ☐ 160 mg SQ at week 0, followed by 80 mg every 4 weeks
QTY: 2 Refill:____
Maintenance: ☐ Inject 80mg SQ every 4 weeks QTY_____ Refills _____
☐ Other: _____ QTY_____ Refills _____

KEVZARA® (sarilumab)
Dose: ☐ 200 mg/1.14 mL PFS ☐ 150 mg/1.14 mL PFS
Dispense: ☐ Inject 150 mg subcutaneously every other week QTY: 2 Refills _____
☐ Inject 200 mg subcutaneously every other week QTY: 2 Refills _____

CIMZIA® (certolizumab pegol)
Initial Dose: ☐ 400mg (two 200mg SQ injections) at weeks 0, 2 & 4 (Starter Kit #6)
Maintenance Dose: ☐ 200mg SQ injection every other week
☐ Other _____ QTY_____ Refills _____

HUMIRA® (adalimumab) Patient wt (kg) _____
Dose ☐ 40mg/0.8mL PFS ☐ 40mg/0.8mL Pens ☐ 20mg/0.4mL PFS
Dispense: ☐ Inject 40mg subcutaneously every other week QTY_____ Refills _____
Juvenile Arthritis ☐ Patient weight 15kg to < 30kg inject 20mg SQ every other week
☐ Patient weight > 30kg inject 40mg SQ every other week

REMICADE 100 mg vial ☐ MD Office Infusion ☐ Home Infusion
Infusion Supplies: ☐ YES ☐ NO
☐ **Starting Dose:** ____mg/kg ____mg on week 0, week 2 & week 6 then,
☐ **Maintenance Dose:** ____mg/kg _____ mg every 8 weeks for ____ infusions every 8 weeks
☐ Other _____ QTY_____ Refills _____

STELARA
Starting Dose: ☐ 45mg ☐ 90mg SQ initially & 4 weeks later QTY: 2
Maintenance Dose: ☐ 45mg ☐ 90mg SQ every 12 weeks QTY_____ Refills _____

☐ **ACTEMRA®** (tocilizumab) Vials Patient wt (kg) _____
☐ 80mg/4ml ☐ 200mg/10ml ☐ 400mg/20ml
Sig: _____
QTY_____ Refills _____

☐ **ACTEMRA®** (tocilizumab) PFS
Inject 162mg (1 syringe) subcutaneously:
☐ every other week (pt wt<100kg)
☐ every week (pt wt >100kg or per clinical response)
QTY_____ Refills _____

SIMPONI® (golimumab) inject 50mg subcutaneously once per month
Dose: *SmartJect™* ☐ 50mg/0.5mL | Prefilled Syringe ☐ 50mg/0.5mL

SIMPONI ARIA® ☐ 50mg/4mL vial QTY _____ (vials) Refills _____
Infuse _____mg (2mg/kg) IV over 30 minutes at weeks 0 and 4, then every 8 weeks

FORTEO® ☐ Pen (#1 pen) ☐ Inject 20mcg SQ Daily Refills _____
☐ Pen Needles 31G 3/16" Qty: 1 Box Refills _____

KINERET® (anakinra) ☐ Inject _____ mg SQ every day Qty _____ Refills _____

ORENCIA® ☐ Inject 125mg subcutaneously weekly Qty 28 day Refills _____
☐ 250mg Vial (IV use only) Loading Dose: 10mg/kg IV x 1 dose,
then 125mg SC weekly, start within 24hrs of IV dose, 1 dose, 4 week supply

XELJANZ® (tofacitinib citrate) ☐ 5mg tablet **XELJANZ XR®** (tofacitinib citrate) ☐ 11mg tablet
Sig: Take ☐ 5mg tablet by mouth twice daily **OR** ☐ 11mg tablet by mouth once daily
QTY _____ Refills _____

ENBREL® **Dose:** PFS ☐ 25mg ☐ 50mg | Multiuse Vial ☐ 25mg | SureClick™ ☐ 50mg
Dispense: ☐ 1x week ☐ 2x week QTY_____ Refills _____

OTEZLA® ☐ 28 day Titration Starter Pack ☐ Tablets
☐ Take as directed *These directions can only be selected for the Titration Starter Pack*
QTY 55 Refills ____
☐ Take 30 mg once daily QTY 30 Refills ____
☐ Take 30 mg twice daily QTY 60 Refills ____

COSENTYX
Starter Dose ☐ Sensoready® Pen ☐ Prefilled Syringe
SIG: ☐ Inject 150 mg dose SQ once weekly for Weeks 0, 1, 2, 3, and 4
QTY: _____ Refills: _____
Maintenance Supply ☐ Sensoready® Pen ☐ Prefilled Syringe
SIG: ☐ Inject 150 mg dose SQ once every 4 weeks QTY _____ Refills _____

OTHER _____
Sig _____QTY _____ Refills _____

By signing this form and utilizing our services, you are authorizing Med Center Specialty Pharmacy and it's employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature (signature required. NO STAMPS)_____ **Date**_____

Please fax completed referral form to **Med Center Specialty Pharmacy** at **304-344-0655** Visit **www.MEDCENTERSPECIALTYPHARMACY.com** for online fillable forms.

NEW REFERRAL CHECKLIST

PLEASE USE THIS CHECKLIST FOR PATIENTS WITH RHEUMATOID ARTHRITIS

Please use the attached checklist as a reference in order to provide the proper documentation to process the required prior authorization for your patient's treatment. All lab reports (or EMR) must contain the following information within the last 30 days.

Please forward any updates to us you receive from the insurance company regarding approvals or denials

REQUIRED INFORMATION:

- ☐ Patient name
- ☐ Patient Demographics (Address, Phone Number, DOB, etc…)
- ☐ Medication list and allergies
- ☐ Insurance information with RX insurance. Please include copy of card.
  If the only card included is a medical card, please include local pharmacy information.
- ☐ MD name/NPI/Office contact/Phone number
- ☐ Drug indicated with refills
- ☐ MD signature and date on referral form
- ☐ Recent TB test results and date
- ☐ Previous treatment
- ☐ Symptoms
- ☐ Clinical notes

Fax the requested documentation to (304) 344-0655

Toll Free: 1-855-633-5633 Direct Phone: (304) 344-8021

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