RE PHARMACY
PASSION FOR LIFE

866 413-3156 toll free phone
877 834-1231 toll free fax
QUESTIONS? Please contact us!
www.REPharmacy.com

Rheumatoid Arthritis Prescription Referral Form

Send your Rx to:

Select Location

Date Medication Needed: _____ Ship To: ☐ Patient's Home ☐ Prescriber's Office ☐ Pick-up (store location): _____ Injection training by pharmacy? ☐

1. Patient Information

Patient Name: _____ Birthdate: _____ Sex: ☐ Male ☐ Female Height: _____ Weight: _____ ☐ lbs. ☐ kg.
Soc. Sec. #: _____ Preferred Phone: _____ Known Allergies: _____
Address: _____ City: _____ State: _____ Zip: _____
Alternate Caregiver Name: _____ Preferred Phone: _____

2. Insurance Information

Please include copies of the FRONT and BACK of ALL insurance cards (prescription and medical) with this fax.

3. Prescriber Information

Provider Name: _____ DEA#: _____ NPI#: _____ Tax ID#: _____
Address: _____ Phone: _____ Fax: _____
City, State, Zip: _____ Key Contact: _____ Phone: _____

4. Diagnosis/Clinical Information

Please FAX recent clinical notes, labs, tests, with the prescription to expedite the prior authorization.

Diagnosis: _____
☐ **Other:** _____
Prior failed medications(medication and duration of treatment/reason for d/c):
☐ _____
Is patient currently on RA therapy? ☐ Yes ☐ No
Medications: _____
TB/PPD test given? ☐ Yes ☐ No

BMD/T-score: _____ **Date:** _____
Does patient have a latex allergy? ☐ Yes ☐ No
Is Patient at risk for osteoporotic fracture as evident by any of the following?
☐ History of osteoporotic fracture Site: _____ Date: _____
☐ Patient has tried and failed an oral bisphosphonate
☐ Patient has documented contraindication/is intolerant to oral bisphosphonate therapy (please submit a copy of DEXA w/prescription)

5. Prescription Information | *Xeljanz NOT to be used in combination with biologic DMARD's*

Medication	Dose/Strength	Sig	Qty.	Refills
☐ **Enbrel®**	☐ 50mg/ml SureClick™ 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:**	4-week supply	
☐ **Forteo®**	☐ 600mcg/2.4ml PFS	☐ Inject 20mcg SC, as directed, once daily	4-week supply	
☐ **Pen Needles**	☐ 31 gauge 6mm		28 needles	
☐ **Humira®** ☐ Injection training from My Humira *(patient must sign below)*	☐ 40mg/0.8ml Pen ☐ 40mg/0.8ml Prefilled Syringe	☐ Inject 40mg SC every OTHER week ☐ Inject 40mg SC ONCE a week	4-week supply	
☐ **Otezla®**	*Please use Otezla-specific referral form available at repharmacy.com*			
☐ **Prolia®**	☐ 60mg Prefilled Syringe	☐ Inject 60mg SC ONCE every 6 months		
☐ **Simponi®**	☐ 50mg/0.5ml Prefilled Syringe ☐ 50mg/0.5ml Autoinjector	☐ Inject 50mg ONCE a month	4-week supply	
☐				
☐				

6. Patient Support Programs

Please sign and date below to enroll in the pharmaceutical company assisted patient support program.

Patient Signature _____ **Date** _____

7. Prescriber Signature

Prescriber, please sign and date below.

By signing below, the prescriber gives consent to both, the prescription(s) above, as well as to RE Pharmacy to act as the prescriber's agent to begin and execute prior authorization process and to help patient apply to co-pay assistance programs, including all foundations and manufacturer assistance programs if necessary.

Dispense as written _____ **Date** _____ **Substitution Permissible** _____ **Date** _____

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately. In no event should such material be read or retained by anyone other than the named addressee, except by express authorization of the sender to the named addressee. **Pursuant to VA/OH/MO/VT law, only 1 medication is permitted per order form. Please use a new form for additional items.**

# of Prescriptions: _____

Faxed prescriptions will only be accepted from a prescribing practitioner. Prescribers are reminded patients may choose any pharmacy of their choice.

©2018 RE Pharmacy