SPS Specialty Pharmacy Services, Inc.

Contact for Office: 787-704-2025 /2028
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Rheumatology Referral Form

Patient Information

Date:_____ Patient SS#:_____ ☐ Male ☐ Female
Patient's First Name:_____ Patient's Last Name:_____
Address:_____ City:_____ State:_____ Zip:_____
Best Phone #:_____ Alternate Phone #:_____
DOB:_____ Caregiver:_____ Allergies:_____ Latex Allergy: Yes ☐ No ☐
Date of Negative TB Test:_____ Hep B ruled out: ☐ Yes ☐ No If no, Treatment started? : Y / N Patient Weight: _____ kg / lb

INSURANCE INFORMATION: PLEASE FAX COPY OF INSURANCE CARD (FRONT & BACK)

Clinical

Diagnosis: ☐ 714.0 Rheumatoid Arthritis ☐ 696.0 Psoriatic Arthritis ☐ 720.0 Ankylosing Spondylitis ☐ Other_____
☐ Date of Diagnosis or Years with Disease:_____

Prior Medications: ☐ Acetaminophen, ibuprofen, naproxen, aspirin ☐ Humira ☐ Enbrel ☐ Methotrexate ☐ Corticosteroids ☐ Celebrex ☐ Indocin ☐ Azulfidine ☐ Other meds tried: _____ Add'l justification for med:_____
Current Medications:_____ **Is patient also taking methotrexate?** ☐ Yes ☐ No

Prescription

Medication	Dose/Strength	Directions	Quantity	Refills
☐ **Actemra®**	☐ 162 mg/0.9 mL Prefilled Syringe	☐ 162 mg Sub-Q every other week ☐ 162 mg Sub-Q once a week	☐ 2 PFS ☐ 4 PFS	
	☐ 80 mg/4 mL Vial ☐ 200 mg/10 mL Vial ☐ 400 mg/20 mL Vial	☐ _____	_____ vial(s)	_____
☐ **Cimzia®**	**Starter Dose** ☐ Starter Kit (200 mg Prefilled Syringes) ☐ 200mg Lyophilized Vial	☐ 400mg Sub-Q at weeks 0, 2, and 4	☐ 1 Kit = 6 x 200 mg/mL PFS ☐ 3 Kits = 3 cartons of 2 x 200 mg Vials	0
	Maintenance Dose ☐ 200mg/ml Prefilled Syringe ☐ 200mg Lyophilized Vial	☐ 400mg Sub-Q every 4 weeks ☐ 200mg Sub-Q every 2 weeks	☐ 1 Carton = 2 x 200 mg/mL PFS ☐ 1 Carton = 2 x 200 mg Vials	_____
☐ **Enbrel®**	☐ 50mg/ml Sureclick™ ☐ 50mg/ml Prefilled Syringe ☐ 25mg Vial (*inj. supplies incl)*	☐ Inject 50mg Sub-Q ONCE a week ☐ Inject 25mg Sub-Q TWICE a week ☐ _____	_____	_____
☐ **Humira®**	☐ 40mg/0.8ml PEN ☐ 40mg/0.8ml Prefilled Syringe ☐ 20mg/0.4ml Prefilled Syringe	☐ Inject 40mg Sub-Q every OTHER week ☐ Inject 40mg Sub-Q ONCE a week ☐ Inject 20mg Sub-Q every OTHER week	☐ 2 ☐ 4	_____
☐ **Orencia®**	☐ 250mg Vial (IV use only)	☐ 10mg/kg IV x 1 dose, then 125mg Sub-Q weekly, start within 24hrs of IV dose	☐ 1 Vial	0
	☐ 125mg/mL Prefilled Syringe	☐ 125mg Sub-Q ONCE a week	☐ 4 Syringes	_____
☐ **Remicade®**	☐ 100 mg Vial (IV use only)	**Induction Dose** ☐ 5mg/kg IV at weeks 0, 2, and 6	_____ vial(s)	_____
	☐ 100 mg Vial (IV use only)	**Maintenance Dose** ☐ 5mg/kg IV every 8 weeks thereafter	_____ vial(s)	_____
☐ **Simponi®**	☐ 50mg/0.5ml SmartJect™ ☐ 50mg/0.5ml Prefilled Syringe	☐ Inject 1 dose (50mg) Sub-Q once monthly	☐ 1 (one)	_____
☐ **Simponi Aria®**	**Starter Dose** ☐ 50mg (4mL) vial(s)	☐ 2 mg/kg IV infusion over 30 min at Week 0	☐ ___ vial(s)	0
	Maintenance Dose ☐ 50mg (4mL) vial(s)	☐ 2 mg/kg IV infusion over 30 min at Week 4 and every 8 weeks thereafter	☐ ___ vial(s)	_____
☐ **Stelara®**	☐ 45mg/0.5mL Prefilled Syringe ☐ 90mg/1mL Prefilled Syringe	☐ Initiation Dose: Inject 1 prefilled syringe Sub-Q Day 1	☐ 1 PFS	0
		☐ Maintenance Dose: Inject the contents of 1 prefilled syringe Sub-Q starting Day 29 & every 12 weeks thereafter	☐ 1 PFS	_____
☐ **Xeljanz®**	☐ 5mg tablet	☐ Take 1 tablet by mouth twice daily	☐ 60 tablets	_____

Patient Support

Enbrel Injection Training or Nurse Support: ENBREL *Support*™ RN to provide education & training ☐ No Nurse ☐

Humira Injection Training or Nurse Support: **Physician Signature required for Injection Training**
myHUMIRA Nurse (RN) visit to provide education & training : Patient's Home or Clinic Site ☐ Physician's Office ☐ No Nurse ☐

Simponi Injection Training or Nurse Support: SimponiOne RN to provide education & training for Sub-Q injection ☐ No Nurse ☐

Prescriber Information

Date Shipment Needed:_____ Ship to: _____Patient _____Physician/Clinic
Ship to Other:_____
Physician Name (please print): _____ Contact Name: _____
Phone #: _____ Fax #: _____ NPI #: _____
Office Address_____ City: _____ State: _____ Zip: _____

I authorize SPS Specialty Pharmacy Services and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

Physician's Signature:_____ Date:_____