

Specialty Pharmacy

Phone: 866.892.1580 • Fax: 866.892.2363

Date Shipment Needed:	Ship To: □Patient □Prescriber				
□ Nursing needed; □ Training needed ► All the supplies including syringes and needles will be dispensed if needed.					

BIOSIMII AR RHEUMATOLOGY NON-IV REFERRAL FORM

Patient Name: DOB: Sex: M F Other: Weight: Ibb. kg. SSN: Phone: Allergies: City: State: Zip: Emergency Contact: Phone: Additional information attached PRESCRIBER INFORMATION Prescriber: NPI: DEA: State Lic: Supervising Physician: Practice Name: Address: City: State: Zip: Phone: State Lic: Supervising Physician: Practice Name: Address: City: State: Zip: Phone: Fax: Key Office Contact: Phone: Ph	PATIENT INFORMATION								
Address: City: State: Zip: Emergency Contact: Phone:	Patient Name:	DOB:	Sex: □M □F □Other:		Weight:	□lbs. □kg.			
Emergency Contact: Phone: Additional information attached PRESCRIBER INFORMATION	SSN: Phone:	Allergies:							
Prescriber: NPI: DEA: State Lic: Supervising Physician: Practice Name: Address: City: State: Zip: Phone: Fax: Key Office Contact: Phone: DIAGNOSIS INFORMATION / MEDICAL ASSESSMENT Primary Diagnosis: M06.9 Rheumatoid Arthritis	Address:		City:						
Prescriber: NPI: DEA: State Lic: Supervising Physician: Practice Name: Address: City: State: Zip: Phone: Fax: Key Office Contact: Phone: DIAGNOSIS INFORMATION / MEDICAL ASSESSMENT Primary Diagnosis: M06.9 Rheumatoid Arthritis L40.54; L40.59 Psoriatic Arthritis M08.00 Polyarticular Juvenile Rheumatoid Arthritis M08.00 Juvenile Idiopathic Arthritis L40.0 Plaque Psoriasis M45.9 Ankylosing Spondylitis M33.20 Polmyositis M81.0 Osteoporosis M15.0; M15.9 Osteoarthritis Other: - Has patient been treated previously for this condition? Yes No Is patient currently on therapy? Yes No Please list medication(s) and treatment duration: - Will patient stop taking the above medication(s) before starting the new medication? Yes No If yes, how long should patient wait before starting the new medication? - Other medications patient is currently taking including OTC medications with dosage and direction (or fax medication profile): - Has patient received a Quatiferon gold, Tspot, or PPD (tuberculosis) Skin Test? Yes No Date: Results: Negative Positive - Prior to initiating treatment and periodically during therapy, patient should be evaluated for active tuberculosis and tested for latent infection - PRESCRIPTION INFORMATION Humira® 40 mg/ 0.4 mL Pen CF 40 mg/ 0.2 mL Prefilled Syringe CF 10 mg/ 0.2 mL Prefille	Emergency Contact:	Phone:		☐ Additional inform	nation attached				
Supervising Physician: Address: City: State: Zip: Phone: Phone: Primary Diagnosis: M06.9 Rheumatoid Arthritis L40.54; L40.59 Psoriatic Arthritis M08.00 Polyarticular Juvenile Rheumatoid Arthritis M08.00 Juvenile Idiopathic Arthritis L40.0 Plaque Psoriasis M45.9 Ankylosing Spondylitis M33.20 Polmyositis M81.0 Osteoporosis M15.0; M15.9 Osteoarthritis Other: Has patient been treated previously for this condition? Primary Diagnosis: M66.9 Rheumatoid Arthritis M68.00 Juvenile Idiopathic Arthritis M68.00 Ju	PRESCRIBER INFORMATION								
Address: City: State: Zip: Phone: Fax: Key Office Contact: Phone: DIAGNOSIS INFORMATION / MEDICAL ASSESSMENT Primary Diagnosis: M06.9 Rheumatoid Arthritis L40.54; L40.59 Psoriatic Arthritis M08.00 Polyarticular Juvenile Rheumatoid Arthritis M08.00 Juvenile Idiopathic Arthritis L40.0 Plaque Psoriasis M45.9 Ankylosing Spondylitis M33.20 Polmyositis M81.0 Osteoporosis M15.0; M15.9 Osteoarthritis Other: Has patient been treated previously for this condition? Yes No Is patient currently on therapy? Yes No Please list medication(s) and treatment duration: Will patient stop taking the above medication(s) before starting the new medication? Yes No If yes, how long should patient wait before starting the new medication? Other medications patient is currently taking including OTC medications with dosage and direction (or fax medication profile): Has patient received a Quatiferon gold, Tspot, or PPD (tuberculosis) Skin Test? Yes No Date: Results: Negative Positive Prior to initiating treatment and periodically during therapy, patient should be evaluated for active tuberculosis and tested for latent infection PRESCRIPTION INFORMATION Prefilled Syringe CF 10 mg/ 0.4 mL Prefilled Syringe CF 10 mg/ 0.2 mL Prefilled Syringe CF 10 mg/		NPI:	,	State	Lic:				
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Primary Diagnosis:			Key Office Contact:	Phone:					
□ L40.0 Plaque Psoriasis □ M45.9 Ankylosing Spondylitis □ M33.20 Polmyositis □ M81.0 Osteoporosis □ M15.0; M15.9 Osteoarthritis □ Other: ■ Has patient been treated previously for this condition? □ Yes □ No □ Is patient currently on therapy? □ Yes □ No □ Please list medication(s) and treatment duration: ■ Will patient stop taking the above medication(s) before starting the new medication? □ Yes □ No □ If yes, how long should patient wait before starting the new medication? ■ Other medications patient is currently taking including OTC medications with dosage and direction (or fax medication profile): ■ Has patient received a Quatiferon gold, Tspot, or PPD (tuberculosis) Skin Test? □ Yes □ No □ Date: □ Results: □ Negative □ Positive Prior to initiating treatment and periodically during therapy, patient should be evaluated for active tuberculosis and tested for latent infection PRESCRIPTION INFORMATION Humira® □ 40 mg/ 0.4 mL Pen CF □ 40 mg/ 0.4 mL Prefilled Syringe CF □ 20 mg/ 0.4 mL Prefilled Syringe CF □ 10 mg/ 0.2 mL Prefilled Syringe CF □ 10 mg/ 0.2 mL Prefilled Syringe CF									
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Has patient received a Quatiferon gold, Tspot, or PPD (tuberculosis) Skin Test? □Yes □No Date: □ Results: □Negative □Positive Prior to initiating treatment and periodically during therapy, patient should be evaluated for active tuberculosis and tested for latent infection PRESCRIPTION INFORMATION Humira® □40 mg/ 0.4 mL Pen CF □40 mg/ 0.4 mL Prefilled Syringe CF □20 mg/ 0.4 mL Prefilled Syringe CF □10 mg/ 0.2 mL Prefilled Syringe CF □20 mg/ 0.4 mL Prefilled Syringe CF □10 mg/ 0.2 mL Prefilled Syringe CF	■ Will patient stop taking the above medication(s) before starting the new medication? □Yes □No If yes, how long should patient wait before starting the new medication?								
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□ 40mg SQ every week □ 40mg SQ every other week	☐ 40mg SQ every week ☐ 40mg SQ every other week			C)TY:	Refills:			

Prescriber's Signature: DAW (Dispense as Written) Date: Prescriber certifies that this referral form contains an original signature and is signed by the treating prescriber. NO STAMPED SIGNATURES WILL BE ACCEPTED. Where required by law, send prescription on official state