CALIFORNIA SPECIALTY PHARMACY

Rheumatology Referral Form

Physicians must fax the completed referral form to California Specialty Pharmacy at 866-853-6555

Your CSP Contact: _____ and Tel: _____

PATIENT INFORMATION:

Patient Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Alternate Phone: _____
Email: _____
Soc. Sec#: _____ Weight: _____ ☐ kg ☐ lbs Height: _____ ☐ ft ☐ cm
Date of Birth: _____ Sex: ☐ Male ☐ Female BSA: _____

PHYSICIAN INFORMATION: Ship to: ☐Physician's Office ☐Patient's Home

Physician Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____
Office Email: _____
Key Office Contact: _____
State LIC #: _____ NPI# _____ DEA# _____

INSURANCE INFORMATION: ☐ **DEMOGRAPHIC SHEET** ☐ **UNIVERSAL CLAIM FORM** ☐ **INSURANCE CARDS (front + back)**

**Please include demographic sheet along with Universal Claim Form for insurance records or reimbursement. (Attach Copies of cards)*

CLINICAL DIAGNOSIS: *please fax or email relevant clinical notes, labs, tests and previous medical history to expedite prior authorization*

Diagnosis / ICD-10 _____
Date of Diagnosis or Years with Disease: _____
Has patient been previously treated for this condition? ☐ Y ☐ N
Is the patient taking methotrexate? ☐ Y ☐ N Latex allergy: ☐ Y ☐ N

☐ Mild ☐ Moderate ☐ Severe Prior Treatment Dates: _____
Is patient currently on therapy? ☐ Y ☐ N
Will patient terminate current therapy upon start of new prescription? ☐ Y ☐ N
BMD/T-Site & Score & Date: _____
TB/PPD Test: ☐ Yes ☐ No Results: _____

Per state-specific law, prescriptions will be dispensed as generic, if applicable, unless noted otherwise: _____

MEDICATIONS & DIRECTIONS

Prescription	Directions	Quantity		Refill
☐ **Actemra®** (tocilizumab)	☐ Inject 162 mg subcut every week ☐ Inject 162 mg subcut every other week ☐ _____	☐ 4 x 162 mg/0.9mL ☐ 2 x 162 mg/0.9mL ☐ _____	☐ Pen ☐ PFS ☐ Vials	_____
☐ **Benlysta®**	☐ 10 mg/kg or _____ mg IV at 2-Week intervals for the first 3 doses and at 4-week intervals thereafter	☐ 56 day supply (Induction)	Vials	0
	☐ 10 mg/kg or _____ mg IV every 4-weeks	☐ 28 day supply		_____
	☐ Inject 400 mg subcut once weekly for 4 doses then 200 mg once weekly	☐ 8 x 200 mg/mL		_____
	☐ Inject 200 mg subcut once weekly	☐ 4 x 200 mg/mL	☐ Pen ☐ PFS	_____
☐ **Cimzia®** (certolizumab)	☐ Inject 400 mg subcut at weeks 0, 2 and 4	☐ 6 x 200 mg/mL	☐ PFS ☐ Vials	0
	☐ Inject 200 mg subcut every 2 weeks ☐ Inject 400 mg subcut every 4 weeks	☐ 2 x 200 mg/mL	☐ PFS ☐ Vials	_____
☐ **Cosentyx®** (secukinumab)	☐ Inject 150 mg subcut once weekly at weeks 0, 1 ,2, and 3	☐ 4 x 150 mg/mL	☐ Sensoready® Pen ☐ PFS	0
	☐ Inject 300 mg subcut once weekly at weeks 0, 1 ,2, and 3	☐ 8 x 150 mg/mL		
	☐ Inject 150 mg subcut on week 4 and every 4 weeks thereafter	☐ 1 x 150 mg/mL	☐ Sensoready® Pen ☐ PFS	_____
	☐ Inject 300 mg subcut on week 4 and every 4 weeks thereafter	☐ 2 x 150 mg/mL		
☐ **Enbrel®** (etanercept)	☐ Inject 25 mg subcut every week	☐ 4 x 50 mg/mL	☐ SureClick® Autoinjector ☐ Mini Cartridge ☐ PFS	_____
☐ **Humira®** (adalimumab)	☐ Inject 40 mg subcut every other week (≥30kg)	☐ 2 x 40 mg/0.4mL **CF**	☐ PFS ☐ Pens	_____
	☐ Inject 40 mg subcut every other week (≥30kg) ☐ Inject 40 mg subcut once weekly	☐ 2 x 40 mg/0.8mL	☐ PFS ☐ Pens	
	☐ Inject 40 mg subcut every other week (≥30kg) ☐ Inject 40 mg subcut once weekly	☐ 4 x 40 mg/0.4 mL **CF**	☐ PFS ☐ Pens	
	☐ Inject 40 mg subcut once weekly	☐ 4 x 40 mg/0.8mL	☐ PFS ☐ Pens	
	☐ Inject 40 mg subcut once weekly	☐ 2 x 150 mg/1.14mL	PFS	
		☐ 2 x 200 mg/1.14mL	PFS	
☐ **Kevzara®** (sarilumab)	☐ 8 mg given as an intravenous infusion every two week for chronic Gout	☐ 2 x 8 mg/mL	PFS Vials	_____
☐ **Krystexxa®**				_____

Prescriber Signature Required ****Prescription is void if the number of drugs prescribed is not noted***

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

PRESCRIBER SIGNATURE	DATE	NO. OF DRUGS PRESCRIBED _____ ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
x		

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Address: _____	Address: _____
City: _____ State: _____ Zip: _____	City: _____ State: _____ Zip: _____
Home Phone: _____ Alternate Phone: _____	Phone: _____ Fax: _____
Email: _____	Office Email: _____
Soc. Sec#: _____ Weight: _____ ☐ kg ☐ lbs Height: _____ ☐ ft ☐ cm	Key Office Contact: _____
Date of Birth: _____ Sex: ☐ Male ☐ Female BMI: _____	State LIC #: _____ NPI# _____ DEA# _____

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TB/PPD Test: ☐ Yes ☐ No Results: _____

Per state-specific law, prescriptions will be dispensed as generic, if applicable, unless noted otherwise: _____

MEDICATIONS & DIRECTIONS

Prescription	Directions	Quantity		Refill
☐ **Orencia®** (abatacept)	☐ Infuse _____ mg intravenously at week 0 only ☐ Infuse _____ mg intravenously at weeks 0 and 2 (JIA <75 kg: 10 mq/kq: JIA ≥75 kg or RA:<60 kg: 500 mg. 60-100 kg: 750 mg. >100 kg: 1000mg)	☐ 28 day supply	Vials	0
	☐ Infuse _____mg at week 4 and every 4 weeks thereafter (JIA <75 kg:10 mg/kg; JIA 75-100 kg: 750 mg; JIA >100 kg: 1000 mg; RA: <60 kg:500 mg; RA: 60-100 kg: 750 mg; RA: >100 kg: 1000 mg)	☐ 28 day supply	Vials	_____
	☐ Inject 125 mg subcut once weekly	☐ 4 x 125 mg/mL	☐ PFS ☐ ClickJet™	_____
☐ **Otezla®** (apremilast)	☐ Take as directed per package instructions	☐ 55 tablets	28-day starter pack	0
	☐ Take 30 mg by mouth twice daily	☐ 60 x 30 mg	Tablets	_____
☐ **Rituxan®** (rituximab)	☐ Infuse _____ mg intravenously every _____ weeks	☐ 28 day supply	Vials	
☐ **Simponi®** (golimumab)	☐ Inject 50 mg subcut once a month	☐ 1 x 50 mg/0.5mL	☐ SmartJect® Autoinjector ☐ PFS	_____
☐ **Simponi Aria®** (golimumab)	☐ Infuse _____ mg (2 mg/kg x _____ kg over 30 minutes at weeks 0	☐ 28 day supply	Vials	0
	☐ Infuse _____ mg (2 mg/kg x _____ kg over 30 minutes at week 4 and every 8 weeks thereafter	☐ 56 day supply	Vials	_____
☐ **Stelara®**	☐ Inject 45 mg subcut on Day 1 (≤ 100 kg)	☐ 1 x 45 mg/0.5mL	PFS	0
	☐ Inject 90 mg subcut on Day 1 (> 100 kg)	☐ 1 x 90 mg/mL		
	☐ Inject 45 mg subcut on Day 29 and every 12 weeks thereafter (≤ 100 kg)	☐ 1 x 45 mg/0.5mL	PFS	_____
	☐ Inject 90 mg subcut on Day 29 and every 12 weeks thereafter (> 100 kg)	☐ 1 x 90 mg/mL		
☐ **Xeljanz®** (tofacitinib)	☐ Take 5 mg by mouth twice daily ☐ _____	☐ 60 x 5 mg ☐ _____	Tablets	_____
☐ **Xeljanz XR®** (tofacitinib)	☐ Take 11 mg by mouth once daily	☐ 30 X 11 mg	Tablets	
☐ **Others**				

Prescriber Signature Required ****Prescription is void if the number of drugs prescribed is not noted***

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

PRESCRIBER SIGNATURE	DATE	NO. OF DRUGS PRESCRIBED _____ ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
x		