PALMETTO PHARM
USE AS WRITTEN

Phone: 1-800-275-0139 • Fax: 843-972-9395

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

RHEUMATOLOGY NON-IV REFERRAL FORM

PATIENT INFORMATION

Patient Name:		DOB:	Sex: ☐M ☐F ☐Other:	Weight:	☐lbs. ☐kg.
SSN:	Phone:	Allergies:			
Address:		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: 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

☐ **Cimzia® 200 mg/mL Prefilled Syringe** ☐**Cimzia® 200 mg Vial** ☐ **Enroll in Cimplicity™ Program**
**Cimza vial should be prepared and administered by a healthcare professional. Prefilled Syringe will be dispensed unless vial is requested.*
☐ Starter Dose: 400 mg SQ (2 inj. of 200 mg) initially (Week 0), repeat at Weeks 2 and 4 — QTY: 1 starter kit (6 PFS) Refills: 0
☐ Maintenance Dose: ☐400 mg SQ (2 inj. of 200 mg) every 4 weeks ☐200 mg SQ every 2 weeks — QTY: 1 box (2 inj.) Refills:
☐ Alternate Dose: _____ — QTY: _____ Refills: _____

☐ **Cosentyx® 150 mg/mL Prefilled Syringe** ☐**Cosentyx® 150 mg/mL Sensoready Pen**
☐ Starter Dose: 150 mg SQ at Weeks 0, 1, 2, 3 and 4
☐ Starter Dose: 300 mg SQ at Weeks 0, 1, 2, 3 and 4 — QTY: _ Refills: 0
☐ Maintenance Dose: 150 mg SQ every 4 weeks — QTY: _ Refills: 0
☐ Maintenance Dose: 300 mg SQ every 4 weeks — QTY: _ Refills:
☐ Alternate Dose: _____ — QTY: _____ Refills: _____

☐ **Enbrel® 50 mg/mL Sureclick (Autoinjector)** ☐**Enbrel® 50 mg/mL Prefilled Syringe** **Not to be sued in pediatric weighing less than 63 kg (138 lb.)* ☐ **Enroll in Enliven® Program**
☐ 50 mg SQ weekly — QTY: 4 Refills: _____
☐ Alternate Dose: _____ — QTY: _____ Refills: _____

☐ **Enbrel® 25 mg/ 0.5 mL Prefilled Syringe**
☐ 25 mg SQ BIW (72-96 hours apart) — QTY: 8 Refills: _____
☐ Alternate Dose: _____ — QTY: _____ Refills: _____

☐ **Humira® 40 mg/ 0.4 mL Pen CF** *NDC: 0074-0554-02* ☐**Humira® 40 mg/ 0.4 mL Prefilled Syringe CF** *NDC: 0074-0243-02* ☐ **Enroll in Humira Complete Program**

☐ **Humira® 20 mg/ 0.4 mL Prefilled Syringe CF** ☐**Humira® 10 mg/ 0.2 mL Prefilled Syringe CF**
☐ 40 mg SQ every other week ☐20 mg SQ every other week ☐10 mg SQ every other week ❑40 mg SQ every week — QTY: _____ Refills: _____
☐ Alternate Dose: _____ — QTY: _____ Refills: _____

☐ **Kevzara® Inj. (Sarilumab) Single Prefilled Syringe** ☐**Kevzara® Inj. (Sarilumab) Single Prefilled Pen** Days' Supply: ☐30 ☐90
☐ 150 mg/1.14 mL ☐200 mg/1.14 mL ☐1 SQ inj. every 2 weeks — QTY: _____ Refills: _____

☐ **Otezla Tablet**
☐ Five (5) day titration period: day 1: 10 mg, day 2: 10 mg BID, day 3: 10 mg then 20 mg BID, day 4: 20 mg BID, day 5: 20 mg then 30 mg BID — QTY: _____ Refills: _____
☐ After five (5) day titration period, 30 mg BID — QTY: _____ Refills: _____

☐ **Orencia® 125 mg/mL SQ Prefilled Syringe (and 250 mg Vial for Starter Dose)** ☐**Orencia® 125 mg/mL ClickJect (Autoinjector) for SQ** ☐ **Enroll in Orencia OnCall Program**
☐ Starter Dose: One dose of IV infusion (per body weight) — QTY: 28 day QS for 1 IV dose and SQ (4 syringes) Refills: 0
☐ Less than 60 kg, dose: 500 mg ❑60-100 kg, dose: 750 mg
☐ Greater than 100 kg, dose: 1000 mg then 125 mg SQ with a day of IV followed by 125 mg SQ every week after
☐ Maintenance Dose: 125 mg SQ every week — QTY: _____ Refills: _____
☐ Other: — QTY: _____ 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 prescription blank. In the event requested agent is not available through Palmetto Specialty Pharm, this prescription shall be forwarded to an eligible pharmacy.

07.28.2022

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Note: Patients transitioning from Orencia IV to Orencia SQ. Administer the first SQ dose instead of the next scheduled IV dose.

PATIENT INFORMATION

Patient Name:			DOB:
Address:	City:	State:	Zip:

INSURANCE INFORMATION

☐ **Please attach front and back of patient's insurance card (medical and prescription)**

COPAY CARD ENROLLMENT

☐ **Please check if enrolling in copay card**	**Copay ID:**

PRESCRIPTION INFORMATION

☐ **Rinvoq® 15 mg Oral Tablet**
Take one tablet orally once daily with or without food — QTY: 30 — Refills:_____

☐ **Siliq® 210 mg/1.5 mL Prefilled Syringe** — QTY: _____ — Refills:_____
210 mg SQ at Weeks 0, 1, 2 followed by 210 mg once every 2 weeks

☐ **Skyrizi® 150 mg/ml Pen** ☐ **Skyrizi® 150 mg/ml Prefilled Syringe**
☐ Inj. 150mg SQ at week 0 — QTY: 1 — Refills: 0
☐ Inj. 150mg SQ every 12 weeks (starting at week 4) — QTY: 1 — Refills:_____

☐ **Simponi® 50 mg/0.5 mL SmartJect (Autoinjector)** ☐ **Simponi® 50 mg/0.5 mL Prefilled Syringe** ☐ **Enroll in SimponiOne Program**
☐ 50 mg SQ every month — QTY:_____ — Refills:_____
☐ Alternate Dose:_____ — QTY: _____ — Refills:_____
☐ 80 mcg SQ once daily — QTY: _____ — Refills:_____

☐ **Xeljanz® 5 mg Tablet**
☐ 5 mg PO BID — QTY:_____ — Refills:_____
☐ 5 mg PO QD — QTY: _____ — Refills:_____

☐ **Xeljanz® XR 11 mg Tablet**
☐ 11 mg PO QD (can begin the day after the last dose of 5 mg IR) — QTY: _____ — Refills:_____

☐ **Other:**_____ — QTY: _____ — Refills:_____

Physician's Signature: _____ ☐ DAW (Dispense as Written) **Date:** _____

Prescriber certifies that this referral form contains an original signature and is signed by the treating physician. NO STAMPED SIGNATURES WILL BE ACCEPTED. Where required by law, send prescription on official state prescription blank. In the event requested agent is not available through Palmetto Specialty Pharm, this prescription shall be forwarded to an eligible pharmacy.