Rheumatology

Fax Referral to: 512-487-5033 Phone: 512-432-5190
Email Referral to: april@martinsspecialtypharmacy.com

Patient Information

Patient Name
Address
City, State, Zip
Primary Phone Emergency Contact Name & Phone Number
Date of Birth ☐ Male ☐ Female
Social Security #

Prescriber Information

Prescriber Name
DEA# NPI# License #
Address
City, State, Zip
Phone Fax
Contact Person

Insurance Information:

Please fax FRONT and BACK copy of prescription and medical insurance cards.

Diagnosis/Clinical Information:

Please fax recent clinical notes, labs and tests with this prescription to expedite the Prior Authorization

Diagnosis: ☐ M06.9 Rheumatoid Arthritis ☐ L40.50 Arthropathic Psosriasis, unspecified ☐ M45.9 Ankylosing Spondylitis, unspecified
☐ M32.10 Systemic Lupus Eryth. ☐ M80 Osteoporosis w/ fracture ☐ M81 Osteoporosis w/o fracture ☐ Other: ICD code _____
Prior Failed Meds: ☐ Methotrexate ☐ Acetaminophen, Ibuprofen, ASA, Naproxen ☐ Humira ☐ Enbrel ☐ Corticostroids
☐ Other Meds tried: _____ Length of Treatment: _____
Reason(s) for Discontinuing Meds: _____
Current Medications: _____
Date of Neg TB Test: _____ Hepatitis B ruled out? ☐Yes ☐No Forteo/Prolia: T-Score: _____ Type: _____ Date: _____
Allergies: _____ Height: _____ Weight: _____

Prescription Information

Medication	Dose / Strength	Directions	Quantity	Refills
Actmra®	☐ 162mg/0.9ml Prefilled Syringe	☐ Inject 1 syringe Sub-Q every week ☐ Inject 1 syringe Sub-Q every other week	☐ 4 week supply	_____
Cimzia®	☐ Starter Kit - 200mg prefilled syringe	☐ Inject 400mg Sub-Q at weeks 0, 2 and 4	☐ 1 kit = 6 x 200mg prefilled syringes	0
	☐ 200mg/ml prefilled syringe	☐ Inject 200mg Sub-Q once every 2 weeks ☐ Inject 400mg Sub-Q once every 2 weeks	☐ 1 box - 2 x 200mg prefilled syringes ☐ 2 boxes - 2 x 200mg prefilled syringes	_____
Cosentryx®	☐ 150mg/ml Prefilled Syringe	☐ Loading Dose: Inject 150mg Sub-Q once weekly at weeks 0, 1, 2, 3 and 4	☐ 5 x 150mg Prefilled Syringes	0
		☐ Inject 150mg Sub-Q every 4 weeks	☐ 4 week supply	_____
Enbrel®	☐ 50mg/ml Autoinjector ☐ 50mg/ml Prefilled Syringe ☐ 25mg/0.5ml Prefilled Syringe	☐ Induction Dose: Inject 50mg Sub-Q TWICE a week (72 - 96 hours apart) for 3 months	☐ 8 Syringes	2
		☐ Inject 50mg Sub-Q every week ☐ Inject 25mg Sub-Q twice a week	☐ 4 Syringes ☐ 8 Syringes	_____
Humira®	☐ 40mg/0.8ml Prefilled Auto Pen ☐ 40mg/0.8ml Prefilled Syringe	☐ Inject 80mg (2x40mg) Sub-Q on Day 1, 40mg on Day 8, then 40mg every other week	☐ 4 week supply	0
		☐ Inject 40mg Sub-Q EVERY OTHER week ☐ Inject 40mg Sub-Q ONCE a week	☐ 4 week supply	_____
Orencia®	☐ 125mg/ml Prefilled Syringe	☐ Inject 125mg Sub-Q ONCE a week	☐ 4 week supply	_____
Otezla®	☐ Therapy Pack	☐ Take 1 tablet by mouth on day 1, then twice daily as directed	☐ 1 Therapy Pack	0
	☐ 30mg Tablets	☐ Take 1 tablet by mouth twice daily	☐ 60 Tablets	_____
Prolia®	☐ 60mg/ml Prefilled Syringe	☐ Inject 60mg Sub-Q once every 6 months	☐ 1 Syringe	_____
Simponi® For psoriatic arthritis	☐ 50mg/0.5ml SmartJect Autoinjector ☐ 50mg/0.5ml Prefilled Syringe	☐ Inject 50mg Sub-Q once every month ☐ Other Dose: _____	☐ 4 week supply	_____
Stelara®	☐ 45mg/0.5ml Prefilled Syringe (for Patients < 220 lbs) ☐ 90mg/1ml Prefilled Syringe (for Patients > 220 lbs)	☐ Inject 45mg Sub-Q initally, the 4 weeks later, than every 12 weeks ☐ Inject 90mg Sub-Q initally, the 4 weeks later, than every 12 weeks	☐ 4 week supply	_____
Xeljanz®	☐ 5mg Tablets	☐ Take tablet by mouth twice daily	☐ 60 Tablets	_____

Prescriber's Signature (no stamp signature) If Brand required check ☐ DAW Date

By signing this form, you are authorizing Martin's Specialty Pharmacy and its representatives to act as your prior authorization designated agent to work with prescription and medical insurance companies to initiate and execute the process.