benevere PHARMACY

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beneverepharmacy.com

TODAY'S DATE: _____

☐ NEW PATIENT ☐ CURRENT PATIENT

Inflammatory Arthritis and Osteoporosis Referral Form

PATIENT INFORMATION

Patient Name _____
Address _____
City _____ State _____ ZIP _____
Home Phone _____ Cell _____
DOB _____ SSN _____
Drug Allergies _____ ☐ Male ☐ Female

PRESCRIBER INFORMATION

Prescriber Name _____ DEA _____
NPI# _____ Tax ID _____
Practice Name _____
Address _____ Suite _____
City _____ State _____ ZIP _____
Office Phone _____ Fax _____

INSURANCE, MEDICARE OR MEDICAID INFORMATION

Primary Prescription Insurance _____
Policy _____ Group _____
Insurance Phone _____

Secondary Prescription Insurance (if applicable) _____
Policy _____ Group _____
Insurance Phone _____

COMPLETE OR FAX FRONT AND BACK COPIES OF INSURANCE, PRESCRIPTION AND/OR CO-PAY ASSISTANCE CARDS

CLINICAL INFORMATION

Primary diagnosis _____ ICD-10 code _____ Patient weight _____ lbs or kgs (please circle) TB/PPD Test Given? ☐ Yes ☐ No

Prior Treatments: ☐ 5-ASA ☐ Azathioprine ☐ Azulfidine ☐ Celebrex ☐ Corticosteroids ☐ Gold Salts ☐ Immunosuppressants ☐ MTX ☐ NSAIDS ☐ Penicillamine ☐ Plaquenil

☐ Previous biologic _____ ☐ Other _____

Currently on a biologic? ☐ Yes ☐ No How long? _____ Date of last dose ____/____/____ This Rx is: ☐ New therapy ☐ Continuing previous treatment on this agent

DRUG NAME		DIRECTIONS FOR USE (PLEASE CHECK ONE OR MORE)	QUANTITY	REFILLS
☐ Actemra® 162mg Prefilled Syringe		☐ < 100kg, Inject 162mg subcutaneously every other week ☐ ≥ 100kg, Inject 162 mg subcutaneously every week		
☐ Cimzia® 200mg Prefilled Syringe		☐ **Induction**: Inject 400 mg subcutaneously on day 1, week 2, and week 4		
		☐ **Maintenance**: Inject 200mg subcutaneously every other week ☐ **Maintenance**: Inject 400mg subcutaneously every 4 weeks		
☐ Cosentyx®	☐ 150mg Sensoready Pen ☐ 150mg Prefilled Syringe	☐ **Induction**: Inject _____mg subcutaneously at weeks 0,1,2,3, and 4	35 Day Supply	0
		☐ **Maintenance**: Inject _____mg subcutaneously every 4 weeks	28 Day Supply	
☐ Enbrel® ☐ 25mg ☐ 50mg	☐ Sureclick Autoinjector ☐ Prefilled syringe ☐ Mini	☐ Inject subcutaneously weekly ☐ Other _____		
☐ Forteo®	☐ Pen and Supplies	☐ Inject 20mcg subcutaneously daily		
☐ Humira® ☐ Humira® Citrate Free	☐ Pens (40mg) ☐ Prefilled syringe	☐ Inject 20mg subcutaneously every other week ☐ Inject 40mg subcutaneously every other week		
☐ Kevzara® ☐ 150mg ☐ 200mg	☐ Prefilled Syringe ☐ Pen	☐ Inject 1 syringe subcutaneously every other week		
☐ Olumiant®	☐ 2mg Tablet	☐ One tablet once daily	30 Day Supply	
☐ Orencia®	☐ 250mg Vial ☐ 125mg Prefilled syringe ☐ 125mg ClickJect	☐ **Infusion**: Initial dose _____ mg intravenously (no refill) ☐ **Subcutaneous**: Inject 125mg subcutaneous weekly (first dose, one day after infusion)		
☐ Otezla®		☐ **Starter Pack**: Take as follows: Day 1 - 10mg in AM, Day 2 - 10mg in AM/10mg in PM, Day 3 - 10mg in AM/20mg in PM, Day 4 - 20mg in AM/20mg in PM, Day 5 - 20mg in AM/30mg in PM, Day 6 and after 30mg twice daily	28 Day Supply	0
		☐ **Maintenance:** Take 30mg by mouth twice a day.	30 Day Supply	
		☐ **Bridge:** Take 30mg by mouth twice a day, dispensed by OSP.	14 Day Supply	12
☐ Otrexup®	☐ 10mg ☐ 12.5mg ☐ 15mg ☐ 17.5mg ☐ 20mg ☐ 22.5mg ☐ 25mg	Inject 1 pen subcutaneously every week		
☐ Prolia®		☐ Inject 60mg subcutaneously once every 6 months		
☐ Rasuvo®	☐ 7.5mg ☐ 10mg ☐ 12.5mg ☐ 15mg ☐ 17.5mg ☐ 20mg ☐ 22.5mg ☐ 25mg ☐ 27.5mg ☐ 30mg	Inject 1 pen subcutaneously every week		
☐ Simponi® 50mg/0.50ml	☐ SmartJect™ ☐ Prefilled syringe	☐ Inject 50mg subcutaneously every 4 weeks		
☐ Stelara®		☐ ≤100kg, Inject 45 mg subcutaneously day 1, week 4, and then every 12 weeks ☐ >100kg, Inject 90 mg subcutaneously day 1, week 4, and then every 12 weeks	28 Day Supply	0
			84 Day Supply	
☐ Tymlos®	☐ Pen and Supplies	☐ Inject 80mcg subcutaneously daily.		
☐ Xeljanz®		☐ Take 5mg tablet twice daily	30 Day Supply	
☐ Xeljanz XR ®		☐ Take 11mg tablet once daily		

Deliver to:
☐ Patient's Home
☐ Physician's Office
☐ 1st dose to MD's Office, remaining refills to patient's home

Training:
☐ Patient has received injection training
☐ Physician's office to provide injection training
☐ Pharmacy to coordinate injection training

Prescriber's Signature (signature required. NO STAMPS) _____ Date _____

By signing this form and utilizing our services, you are authorizing Benevere and it's employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

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If you are not the named addressee, you should not disseminate, distribute or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.