KERR HEALTH
Specialty Pharmacy

# Rheumatology Referral Form

Phone (866) 443-1904 • Fax (877) 465-6091 • www.kerrhealth.com

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|---|---|
| **TODAY'S DATE:** | |
| **DATE SHIPMENT NEEDED:** | |
| ❑ **NEW START** ❑ **CONTINUATION OF THERAPY** | |
| **SHIP TO:** ❑ PATIENT ❑ PHYSICIAN ❑ KERR DRUG STORE: _____ | |

## GENERAL INFORMATION

| | | | |
|---|---|---|---|
| **PATIENT (FIRST NAME, LAST NAME):** | | ADDRESS: | |
| CITY: | STATE: | ZIP: | DOB: |
| SS#: | HOME#: | CELL#: | WORK#: |
| ALLERGIES: | ❑ MALE ❑ FEMALE | HEIGHT: | WEIGHT: |
| CURRENT MEDS: | | | |
| **PHYSICIAN NAME:** | | PRACTICE NAME/HOSPITAL: | |
| ADDRESS: | CITY: | STATE: | ZIP: |
| PHONE#: | FAX#: | STATE LIC#: | DEA#: |
| NURSE/KEY OFFICE CONTACT: | | NPI#: | |

## PRESCRIPTION INSURANCE INFORMATION

| | | | |
|---|---|---|---|
| **PRIMARY INSURANCE:** | | EMPLOYER: | |
| CARDHOLDER NAME: | ID#: | GROUP#: | PHONE#: |
| **SECONDARY INSURANCE:** | ID#: | GROUP#: | PHONE#: |

## STATEMENT OF MEDICAL NECESSITY

**PRIMARY DIAGNOSIS:** ❑ Rheumatoid Arthritis (ICD-9: 714.0) ❑ Ankylosing Spondylitis (ICD-9: 720.0) ❑ Psoriatic Arthritis (ICD-9: 696.0) ❑ Polymyositis (ICD-9: 710.4)
❑ Polyarticular Juvenile Rheumatoid Arthritis (ICD-9: 714.3) ❑ Osteoporosis (ICD-9: 733.0) ❑ Osteoarthritis (ICD-9: 715.0)
❑ Other _____ ICD-9 Code: _____

Has the patient been screened for TB? Results: _____
Has the patient been screened for HBV? HCV? Results: _____
Is the patient known to be HIV positive? ❑ yes or ❑ no
Does the patient have a history of heart failure? ❑ yes or ❑ no
Comments: _____

Does the patient have any of the following exclusion criteria for biologic therapy?
Check all that apply:
❑ Active infection (e.g. chronic leg ulcers, recurrent respiratory infections, indwelling catheter, TB, hepatitis B/C, HIV)
❑ NYHA Class 3 or 4 heart failure ❑ Pregnant/Breast Feeding
❑ Known diagnosis of demyelinating disease
❑ On concomitant biological agent

**Medical Justification for Prescribing Biologic Therapy**
*(or attach relevant history)*
❑ No response to previous treatment (list): _____
❑ Contraindications (list): _____
❑ Side effects, lab abnormalities, toxicity issues (list): _____

**Exclusive to the drug Forteo®:**
Does the patient have a history of any of the following contraindications?
❑ Paget's Disease ❑ Prior radiation therapy
❑ Bone metastasis ❑ Metabolic bone disease
❑ Pre-existing hypercalcemia ❑ H/O Skeletal Malignancies

## PRESCRIPTION INFORMATION

**Enbrel®** ❑ 25 mg PFS ❑ 50 mg Sureclick Pen ❑ 25 mg Vials ❑ 50 mg PFS
Sig: _____
Qty: _____ Refills: _____

**Humira®** ❑ 20 mg PFS ❑ 40 mg PFS ❑ 40 mg Pen ❑ Crohn's Starter Pack ❑ Psoriasis Starter Pack
Sig: _____
Qty: _____ Refills: _____

**Simponi®** ❑ 50 mg PFS ❑ 50 mg Smartject
Sig: Inject subQ monthly _____
Qty: _____ Refills: _____

**Forteo®** ❑ 20 mcg subQ daily Refills: _____
❑ Ultra-Fine Pen Needles 8 mm x 31 g Qty 100 (=1 box)
Other: _____
Qty: _____ Refills: _____

**Cimzia®** ❑ 200 mg vials ❑ 200 mg PFS
❑ New Start
3 Cimzia Kits (2x200 mg)
Sig: Inject 400 mg subQ at weeks 0, 2, and 4
❑ Continuation of Therapy
Qty: 1 kit (2x200mg)
Sig: ❑ Inject 400 mg subQ every 4 weeks ❑ Inject 200 mg every other week
Refills: _____

**Other Medication:** _____ ❑ Dose: _____
Sig: _____
Qty: _____ Refills: _____

If you would like brand names, please write *"Brand Medically Necessary"*. Please note Kerr Health Specialty Pharmacy will dispense our formulary product unless otherwise specified.

I authorize Kerr Health Specialty Pharmacy and its representatives to act as my agents for prior authorization and prescription processing for this patient.

Physician Signature: _____ Date: _____

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