Pharmacy
HyVee SOLUTIONS

RHEUMATOLOGY REFERRAL FORM H-0

877.RxHyVee (877.794.9833)
10004 S. 152nd Street, Suite C
Omaha, NE 68138

Patient Information
PLEASE FAX INSURANCE CARD (FRONT AND BACK)

Last Name	First Name	DOB
Address		
City	State	ZIP
SSN		
Sex ❑ Male ❑ Female	Weight (kg)	Height (ft,in)
Emergency Contact	Phone	
Insurance Plan	Plan ID #	

Prescriber Information

Practice/Facility Name		
Address		
City	State	ZIP
Prescriber Name		
Prescriber NPI		
Nurse/Key Contact	Phone/Pager	
Fax		

Diagnosis/Clinical Information
PLEASE FAX CLINICAL AND LAB INFORMATION

Primary Diagnosis: M06.9 Rheumatoid Arthritis M08.00 Juvenile Rheumatoid Arthritis L40.59 Psoriatic Arthritis L40.54 Psoriatic Juvenile Arthritis M45.9 Ankylosing Spondylitis Other:_______________

Date of diagnosis/years with the disease: _______________

Prior Therapy: No Yes (provide details): _______________

Concurrent Therapy: No Yes (provide details): _______________

TB Test: No Yes (date): _______________ Results: _______________

Prescription Information

MEDICATION	DOSE/STRENGTH	DIRECTIONS FOR USE	QTY	REFILLS
Humira®	40 mg/0.8 ml Pen 40 mg/0.8 ml PFS	Inject 40 mg SC every other week Inject 40 mg SC once a week Other: _______________	4-week supply	
Kevzara®	200 mg/1.14 ml PFS 150 mg/1.14 ml PFS	200 mg SC once every 2 weeks 150 mg SC once every 2 weeks	4-week supply	
Methotrexate®	2.5 mg tablet	Take_____mg (_____tablets) by mouth once weekly on the same day each week	4-week supply	
	25 mg/mL (2 mL vial) Inj	Inject _____mg SQ once weekly on the same day each week	4-week supply	
Orencia® *IV Administration* *Current Weight:* _________kg	Orencia 250 mg vial **Adult** <60 kg = 500 mg 60-100 kg = 750 mg >100 kg = 1,000 mg **Pediatric (6-17 years)** <75 kg = 10 mg/kg 75-100 kg = 750 mg >100 kg = 1,000 mg (max dose)	**Initial Dose:** Infuse _____mg IV at week 0 only, then transition to SC Infuse _____mg IV at week 0 and 2	QS	0
		Maintenance Dose: Infuse _____mg IV at week 4 and then every 4 weeks thereafter	4-week supply	
Orencia® *SC Administration* *Current Weight:* _________kg	Orencia 125 mg/ml PFS Orencia 125 mg/ml ClickJect™ Orencia 87.5 mg/0.7 ml PFS Orencia 50 mg/0.4 ml PFS	**Adult Dose:** 125 mg SC once weekly **Pediatric Dose: (≥ 2 years)** 10 — <25 kg 50 mg SC once weekly ≥25 kg — <50 kg 87.5 mg SC once weekly >50 kg 125 mg SC once weekly	4-week supply	
Otrexup®	Auto-injector: 10 mg/0.4 ml 12.5 mg/0.4 ml 15 mg/0.4 ml 17.5 mg/0.4 ml 20 mg/0.4 ml 22.5 mg/0.4 ml 25 mg/0.4 ml	Inject _____mg SQ once weekly on the same day each week	4	

***For Otezla, please see "Rheumatology O-R" form.**

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary," or your state-specific required language to prohibit substitution: _______________

____
PRODUCT SUBSTITUTION PERMITTED/Brand exchange permitted (date)

____
DISPENSE AS WRITTEN/Do Not Substitute (date)

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