Pharmacy
HyVee SOLUTIONS

RHEUMATOLOGY REFERRAL FORM 0-R

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
Otezla® Adult Dosing	**Starter Pack** (Titration) (55 tablets)	Take as directed per package or prescriber instructions	28 day starter pack	0
	Maintence Rx 30 mg (Otezla tablets)	Take one tablet by mouth twice daily	60	
		Take one tablet by mouth once daily	30	
	Bridge Rx 30 mg (Otezla tablets)	Take one tablet by mouth twice daily	28/14 day supply	12 refills
		Take one tablet by mouth once daily	28/28 day supply	6 refills
Rasuvo®	Auto-injector: 7.5 mg/0.15 ml 10 mg/0.2 ml 12.5 mg/0.25 ml 15 mg/0.3 ml 17.5 mg/0.35 ml 20 mg/0.4 ml 22.5 mg/0.45 ml 25 mg/0.5 ml 30 mg/0.6 ml	Inject______mg SQ once weekly on the same day each week	4	
Remicade® *Current Weight:* ____________kg Biosimilars: Inflectra Renflexis	100 mg Vial	**Initial Dose:** 3 mg/kg (__________mg) IV at week 0 and 2 5 mg/kg (__________mg) IV at week 0 and 2 Other:	QS QS	0 0
		Maintenance Dose: Starting at week 6, infuse 3 mg/kg (______mg) once every 8 weeks Starting at week 6, infuse 5 mg/kg (______mg) once every 8 weeks Starting at week 6, infuse 5 mg/kg (______mg) once every 8 weeks Other:	QS QS QS	

***For Orencia and Otrexup, please see “Rheumatology H-O” 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: ____________________________________

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)

Confidentiality Statement: This message is intended only for the individual or entity to which it is addressed. It may contain information which may be proprietary and confidential. It may also contain privileged, confidential information which is exempt from disclosure under applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA). If you are not the intended recipient, please note that you are strictly prohibited from disseminating or distributing this information (other than to the intended recipient) or copying this information. If you received this communication in error, please notify the sender immediately at the address and telephone number set forth herein and obtain instructions as to proper destruction of the transmitted material. Thank you.

Hy-Vee Pharmacy Solutions © 2018