


Rheumatology Referral Form	Y Medical Associates Fax To: 855-838-0623 Phone: 800-447-7558	
Date: _____		

Patient Information	Prescriber Information
Patient Name: _____	Prescriber Name: _____
Address: _____	Address: _____
City, State, Zip: _____	City, State, Zip: _____
Home Phone: _____	Phone: _____
Cell Phone: _____	Fax: _____
DOB: _____	DEA: _____ NPI #: _____
Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Contact Person: _____

Insurance Information		
Primary Insurance: _____	ID#: _____	Group: _____
Secondary Insurance: _____	ID#: _____	Group: _____
Prescription Card: _____	ID#: _____	BIN#: _____ PCN#: _____ Group: _____

Clinical Information (Please fax all pertinent clinical and lab information)

M06.9 (Rheumatoid Arthritis) M08.0 (Juvenile Idiopathic Arthritis) L40.59 (Psoriatic Arthritis) L40.54 (Psoriatic Juvenile Arthritis)
 M45.9 (Ankylosing Spondylitis) M32.9 (Systemic Lupus Erythematosus) Other: _____
 Diagnosis Date: _____


Diagnosis and Clinical Assessment (Fill in below or attach lab work)

Joints Affected: _____ Number of Tender Joints: _____ CRP: _____ Date: _____
 Number of Swollen Joints: _____ Current Weight: _____ Current Height: _____ Date: _____ ESR: _____ Date: _____
 New Therapy Induction | Stop Date: _____ Therapy Change | Stop Date: _____
 Therapy Continuation | Stop Date: _____ Weeks Completed: 0 2 4 6
 Allergies: _____
 TB Results & Date (Please provide copy of result): _____
 Bone Density Score & Date (Please provide a copy of results): _____

Medication	Dose Strength	Directions	Qty	Refills
Actemra	<input type="checkbox"/> Prefilled Syringe 162mg/0.9mL <input type="checkbox"/> Auto Injector 162mg/0.9mL	<input type="checkbox"/> <100kg Inject 162mg/0.9mL SC every 2 weeks <input type="checkbox"/> >100kg Inject 162mg/0.9mL SC every week		
Benlysta	<input type="checkbox"/> 10mg/kg <input type="checkbox"/> 200mg PFS <input type="checkbox"/> 200mg Autoinjector	<input type="checkbox"/> IV Starter Dose: Infuse 10mg/kg every 2 weeks for 3 doses <input type="checkbox"/> IV Maintenance: Inject 10mg/kg every 4 weeks <input type="checkbox"/> Inject 200mg SC once weekly (if switching from IV administer first SC dose 1-4 weeks after last IV dose)		
Cimzia	<input type="checkbox"/> Starter Kit <input type="checkbox"/> Syringe <input type="checkbox"/> Vial	<input type="checkbox"/> Starter Dose: Inject 400mg SC on week 0, 2, and 4 <input type="checkbox"/> Maintenance Dose: Inject 200mg SC every 2 weeks <input type="checkbox"/> Maintenance Dose: Inject 400mg SC once a month		
Cosentyx	<input type="checkbox"/> 150mg Sensoready Pen <input type="checkbox"/> 300mg Sensoready Pen	<input type="checkbox"/> Starter Dose: Inject 150mg SC on week 0, 1, 2, 3, and 4 <input type="checkbox"/> Maintenance: Inject 150mg SC every 4 weeks <input type="checkbox"/> Starter Dose: Inject 300mg SC on week 0, 1, 2, 3, and 4 <input type="checkbox"/> Maintenance: Inject 300mg SC every 4 weeks	<input type="checkbox"/> 5 <input type="checkbox"/> 1 <input type="checkbox"/> 10 <input type="checkbox"/> 2	
Enbrel	<input type="checkbox"/> 25mg Syringe <input type="checkbox"/> 0.25mg Vial <input type="checkbox"/> 50mg Syringe <input type="checkbox"/> 50mg SureClick Pen <input type="checkbox"/> Mini 50mg/mL	<input type="checkbox"/> Inject 50mg SC every week <input type="checkbox"/> Inject _____ mg(0.8mg/kg x _____ kg) SC every week		
Evenity	<input type="checkbox"/> 105mg/1.17mL	<input type="checkbox"/> Inject 2 syringes (105mg each) for total dose of 210mg SQ once monthly	<input type="checkbox"/> 2	
Forteo	<input type="checkbox"/> 600mcg/2.4mL PFS	<input type="checkbox"/> Maintenance: Inject 20mcg SC once daily	<input type="checkbox"/> 1	
Humira	<input type="checkbox"/> 10mg Syringe <input type="checkbox"/> 20mg Syringe <input type="checkbox"/> 40mg/0.4mL Syringe <input type="checkbox"/> 40mg/0.4mL Pen	<input type="checkbox"/> Inject 10mg SC every other week (10 to <15kg) <input type="checkbox"/> Inject 20mg SC every other week (15 to <30kg) <input type="checkbox"/> Inject 40mg SC every other week (30kg) <input type="checkbox"/> Inject 40mg SC once weekly		

Prescriber Signature: _____ **DAW (Dispense as Written)** **Date:** _____

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Date: _____		

Patient Information	Prescriber Information
Patient Name: _____ Address: _____ City, State, Zip: _____ Home Phone: _____ Cell Phone: _____ DOB: _____ Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Prescriber Name: _____ Address: _____ City, State, Zip: _____ Phone: _____ Fax: _____ DEA: _____ NPI #: _____ Contact Person: _____

Insurance Information		
Primary Insurance: _____	ID#: _____	Group: _____
Secondary Insurance: _____	ID#: _____	Group: _____
Prescription Card: _____	ID#: _____	BIN#: _____ PCN#: _____ Group: _____

Clinical Information (Please fax all pertinent clinical and lab information)
<input type="checkbox"/> M06.9 (Rheumatoid Arthritis) <input type="checkbox"/> M08.0 (Juvenile Idiopathic Arthritis) <input type="checkbox"/> L40.59 (Psoriatic Arthritis) <input type="checkbox"/> L40.54 (Psoriatic Juvenile Arthritis) <input type="checkbox"/> M45.9 (Ankylosing Spondylitis) <input type="checkbox"/> M32.9 (Systemic Lupus Erythematosus) <input type="checkbox"/> Other: _____ Diagnosis Date: _____

Diagnosis and Clinical Assessment (Fill in below or attach lab work)
Joints Affected: _____ Number of Tender Joints: _____ CRP: _____ Date: _____ Number of Swollen Joints: _____ Current Weight: _____ Current Height: _____ Date: _____ ESR: _____ Date: _____ <input type="checkbox"/> New Therapy Induction Stop Date: _____ <input type="checkbox"/> Therapy Change Stop Date: _____ <input type="checkbox"/> Therapy Continuation Stop Date: _____ <input type="checkbox"/> Weeks Completed: <input type="checkbox"/> 0 <input type="checkbox"/> 2 <input type="checkbox"/> 4 <input type="checkbox"/> 6 Allergies: _____ TB Results & Date (Please provide copy of result): _____ <input type="checkbox"/> Bone Density Score & Date (Please provide a copy of results): _____

Medication	Dose Strength	Directions	Qty	Refills
Kevzara	<input type="checkbox"/> 150mg/1.14mL PFS <input type="checkbox"/> 200mg/1.14mL Pen	<input type="checkbox"/> Inject 200mg SC once every 2 weeks <input type="checkbox"/> Other: _____		
Krystexxa	<input type="checkbox"/> 8mg/mL	<input type="checkbox"/> Infuse 8mg in 250mL of NS over 120 minutes once every 2 weeks		
Olumiant	<input type="checkbox"/> 2mg Tablet <input type="checkbox"/> 1mg Tablet	<input type="checkbox"/> Take one tablet PO daily		
Orencia	<input type="checkbox"/> 125mg Pen <input type="checkbox"/> 250mg Vial <input type="checkbox"/> 125mg Pen Syringe	<input type="checkbox"/> IV Dosage: Infuse _____mg at weeks 0, 2, 4 then every 4 weeks thereafter <input type="checkbox"/> SC Dosage: Inject 125mg SC once a week		
Otezla	<input type="checkbox"/> Starter Pack <input type="checkbox"/> 30mg Tablet	<input type="checkbox"/> Starter Pack: Use as directed <input type="checkbox"/> Maintenance Dose: Take one tablet PO BID		
Prolia	<input type="checkbox"/> 60mg PFS	<input type="checkbox"/> Inject 1 syringe SC every 6 months		
<input type="checkbox"/> Avsola <input type="checkbox"/> Inflectra <input type="checkbox"/> Remicade <input type="checkbox"/> Renflexis	<input type="checkbox"/> 100mg Vial	<input type="checkbox"/> Loading Dose: Infuse 5mg/kg at weeks 0, 2, & 6 <input type="checkbox"/> Maintenance Dose: Infuse 5mg/kg every 8 weeks		
Rinvoq	<input type="checkbox"/> 15mg	<input type="checkbox"/> Take 1 tablet PO daily		
<input type="checkbox"/> Rituxan <input type="checkbox"/> Truxima	<input type="checkbox"/> 100mg Vial <input type="checkbox"/> 500mg Vial	<input type="checkbox"/> Infuse 1000mg on day 1 and day 15		

Prescriber Signature: _____	DAW (Dispense as Written) Date: _____
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