Rheumatology Referral Form		Y Medical Associates		YMed	ical		
Date:		Fax:855-838-0623 Phone: 800-447-7558	AGE WAY	ASSOCIATES			
	Patient Information	Pre	scriber Informat	ion			
Patient Name:		Prescriber Name:					
	D:						
Cell Phone:		Fax:	Fax:				
		·	DEA:NPI #: Contact Person:				
Gender: □ M							
		Insurance Information					
		ID#:					
Secondary Ins	surance:	ID#:	ID#: Group:				
Prescription Car		BIN#:PCN#:					
		(Please fax all pertinent clinical and					
		Idiopathic Arthritis) L40.59 (Psoriatic Arthrit			hritis)		
☐ M45.9 (Ank	ylosing Spondylitis) 🗆 M32.9 (	Systemic Lupus Erythematosis) $\;\Box$ Other:					
Diagnosis Dat							
		inical Assessment (Fill in below or atta					
Joints Affected	d:	Number of Tender Joints:	CRP:	_Date:			
		ight:Date:					
		Therapy Chan					
	· · · · · · · · · · · · · · · · · · ·	□ Weeks Cor	npleted: ⊔0 ∟	」2	. ⊔ 6		
	4- (Di manifel f						
	te (Please provide copy of result):	, of reculto).					
	Score & Date (Please provide a cop			Otre	Refills		
Medication Actemra	Dose Strength  ☐ Prefilled Syringe 162mg/0.9mL	Directions  □ <100kg Inject 162mg/0.9mL SUB		Qty	Refilis		
Acternia	☐ Auto Injector 162mg/0.9mL	□ >100kg Inject 162mg/0.9mL SUE	Q every week				
Benlysta	□ 10mg/kg	☐ IV Starter Dose: Infuse 10mg/kg	g every 2 weeks for				
	☐ 200mg PFS☐ 200mg Autoinjector	3 doses	ses aintenance: Inject 10mg/kg every 4 weeks				
	200mg Automjector		antenance: Inject 1011g/kg every 4 weeks at 200mg SUBQ once weekly (if switching				
			n IV administer first SUBQ dose 1-4 weeks after				
		last IV dose)					
Cimzia	☐ Starter Kit ☐ Syringe ☐ Vial	☐ Starter Dose: Inject 400mg SUB					
		<ul><li>☐ Maintenance Dose: Inject 200m</li><li>☐ Maintenance Dose: Inject 400m</li></ul>		5			
Cosentyx	☐ 150mg Sensoready Pen	☐ Starter Dose: Inject 150mg SUB		□ 5			
,	☐ 300mg Sensoready Pen	and 4					
		☐ Maintenance: Inject 150mg SUB		□1			
		☐ Starter Dose: Inject 300mg SUB and 4	Q on week 0, 1, 2, 3,	□ 10			
		☐ <b>Maintenance:</b> Inject 300mg SUB	Q every 4 weeks	□2			
Enbrel	☐ 25mg Syringe ☐ 0.25mg Vial	☐ Inject 50mg SUBQ every week	2 0.0.7	- <del>-</del>			
21.0101	☐ 50mg Syringe ☐ 50mg SureCli	, ,	g xkg) SC				
	☐ Mini 50mg/mL	every week	y week				
Evenity	□ 105mg/1.17mL		2 syringes (105mg each) for total dose of				
Forteo	☐ 600mcg/2.4mL PFS	210mg SUBQ once monthly			□1		
Forteo	☐ 10mg Syringe		ntenance: Inject 20mcg SUBQ once daily ct 10mg SUBQ every other week (10 to <15kg)				
☐ Humira	□ 20mg Syringe		of 10mg SUBQ every other week (10 to <15kg) of 20mg SUBQ every other week (15 to <30kg)				
☐ Adalimumab	☐ 40mg/0.4mL Syringe	☐ Inject 40mg SUBQ every other w	ject 40mg SUBQ every other week (30kg)				
(biosimilar)	☐ 40mg/0.4mL Pen	☐ Inject 40mg SUBQ once weekly	-				

Rheumatology Referral Form			Y Medical Associates		VMad	امدا		
Date:			:855-838-0623 e: 800-447-7558		YMedical ASSOCIATES			
	Patient Informat	tion	Pre	escriber Informa	tion			
Patient Name:			Prescriber Name:					
Address:			Address:					
-	D:		City, State, Zip:					
			Phone:					
			Fax:	NIDL "				
			DEA:					
Gender: $\square$ M	I ⊔F		Contact Person:					
			ce Information	_				
			ID#: Group: ID#: Group:					
			ID#: BIN#:PCN#:					
Prescription C								
□ Moc o /Dha		•	all pertinent clinical and		etia lauranila Anth	\ 		
,	,	•	ritis) L40.59 (Psoriatic Arthri	,		ritis)		
Diagnosis Dat		32.9 (Systemic Lupu	s Erythematosis) □ Other: _					
Diagnosis Dat		and Clinical Assess	sment (Fill in below or atta	ach lah work)				
Joints Affected			r of Tender Joints:					
			Current Height:Date:					
			Therapy Char					
			□ Weeks Cor			□ 6		
_								
-	Score & Date (Please provid							
Medication	Dose Streng		Directions		Qty	Refills		
Kevzara	150mg/1.14mL PFS	200mg/1.14mL Pen	☐ Inject 200mg SUBQ once e☐ Other:	•				
Krystexxa	□ 8mg/mL		☐ Infuse 8mg in 250mL of NS over 120 minutes once every 2 weeks					
Olumiant	□ 2mg Tablet	☐ 1mg Tablet	☐ Take one tablet PO daily					
Orencia		☐ 250mg Vial	□ IV Dosage: Infuse mg at weeks 0, 2, 4					
	☐ 125mg Pen Syringe		then every 4 weeks thereafter  SUBQ Dosage: Inject 125mg SUBQ once a week					
011-	Don't Don't	□ 00 <b>T</b> -bl-4	• ,	•				
Otezla	☐ Starter Pack	☐ 30mg Tablet	☐ Starter Pack: Use as directe☐ Maintenance Dose: Take o					
Prolia	□ 60mg PFS		☐ Inject 1 syringe SUBQ every	6 months				
☐ Avsola	☐ 100mg Vial		☐ <b>Loading Dose</b> : Infuse 5mg/kg at weeks 0, 2, & 6					
<ul><li>□ Inflectra</li><li>□ Remicade</li></ul>			☐ <b>Maintenance Dose:</b> Infuse 5mg/kg every 8					
☐ Renflexis			weeks					
Rinvoq	☐ 15mg		☐ Take 1 tablet PO daily					
☐ Rituxan	-	☐ 500mg Vial	☐ Infuse 1000mg on day 1 ar	nd day 15				
☐ Truxima	_ roomy viai	_ Jooning viai	Liniuse roooning on day 1 and day 15					

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Prescriber Signature:

DAW (Dispense as Written) Date:

Rheumatology Referral Form  Date:		Fax:85	ical Associates 855-838-0623 e: 800-447-7558			YMedical ASSOCIATES		
P	atient Information			Pre	scriber In	forma	tion	
			Prescriber	Name:				
Address:								
Home Phone:			1	• •				
DOB:			DEA:		N	IPI#:		
Gender: □ M □ F				son:				
		Insurance Ir	nformatio	n				
Primary Insurance:					Grou	p:		
Prescription Card:	ID#:	BI	IN#:	PCN#:	Gro	no:		
	Clinical Information (P							
□ MOC 0 (Phaumataid A	Arthritis) M08.0 (Juvenile Idio					•	tia luuranila	Arthritia)
•	Spondylitis) 🗆 M32.9 (Syst	. ,	•		•	•		Artinus)
Diagnosis Date:		emic Lupus Ery	/inemaiosis	ı ⊔ Omer				
Diagnosis Date.		al Assassmen	4 /Fill in he	Jaw ar atte	ah lah wa	wle)		
lainta Affactad	Diagnosis and Clinic					,	Dotos	
Number of Swellen Joint	s:Current Weight	inumber of i	i ender Joint et Height:	S:	CRP	TCD.	_Date:	
	on   Stop Date:							
	on   Stop Date:		⊔ V	veeks Cor	npietea. L	J <b>O</b> L	J	4 🗆 0
Allergies:								
·	se provide copy of result): Date (Please provide a copy of	roculta):						
		results)					24	D-CII-
Medication Simponi/Simponi Aria	Dose Strength   Simponi:	Simponi:	Directi	ons		•	Qty	Refills
Simponi/Simponi Ana	☐ SmartJect 50mg/0.5mL	☐ Inject 50mg	SUBQ once i	ner month				
	□ 50mg/0.5mL PFS	Simponi Aria	:					
	Simponi Aria:	☐ Infuse	m	g(2mg/kg) IV	over 30			
	☐ 50mg/4mL Vial		and 4 weeks		8 weeks			
Stelara	☐ 45mg/0.5mL PFS	☐ Inject 45mg						
	☐ 90mg/mL PFS	☐ Inject 90mg			40			
		☐ Inject 45mg	eafter (<100		y 12			
		☐ Inject 90mg			v 12			
			eafter (>100		,			
Skyrizi	☐ 150 mg/mL in each single-	☐ Initial Dose:	Inject 150mg	SUBQ weeks	0, and 4			
•	dose prefilled pen	☐ Maintenanc	e Dose: Inject	150mg SUBO	Qevery			
	☐ 90 mg/mL in each single-	12 weeks						
	dose prefilled syringe  ☐ 150 mg/mL in each single-							
	dose prefilled syringe							
Taltz	☐ 80mg/mL AutoInjector	☐ Starter Dos						
		☐ Maintenand	ce: Inject 80m	g SUBQ ever	y 4 weeks			
Tremfya	100mg PFS	☐ Inject SUB0	Q 100 mg at w	eeks 0. 4. ar	d then			
·	100mg One-Press autoinjector		eeks thereaf					
Tymlos	□ 80mcg/0.04mL	☐ Inject 80mc	ca SUBQ onc	e daily into p	eriumbilical	☐ 1-Pre	efilled Pen	
1 /111100			e with supple				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
		vitamin D i	f dietary inta					
Xeljanz/XR	Xeljanz:	Xeljanz:						
	☐ 5mg Tablet	☐ Take one ta	ablet twice da	ily		□ 60		
	Xeljanz XR:	Xeljanz XR:	ablat anaa da:	lv.		□ 20		
	☐ 11mg Tablet	☐ Take one ta	abiet once dai	ıy		□ 30		
<b>B</b> 11 <b>S</b> 1			<b></b>					
Prescriber Signature:			DAW (Dis	pense as Wr	itten) Date	:		