RHEUMATOLOGY REFERRAL FORM

Date: _____

Hometech Advanced Therapies

Fax Referral To: 855-884-9283

Phone: 855-494-3121

HOMETECH ADVANCED THERAPIES

Needs by Date: _____ Ship to ☐ Patient's Home ☐ Prescriber 1st Order Only ☐ Prescriber All Orders

PATIENT INFORMATION

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Cell Phone: _____
Date of Birth: _____ Gender: ☐ M ☐ F

PRESCRIBER INFORMATION

Prescriber Name: _____
Address: _____
City, State, Zip: _____
Phone: _____ Fax: _____
DEA#: _____ NPI#: _____
Contact Person: _____

INSURANCE INFORMATION *(Please attach the front and back of insurance and prescription drug card)*

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

DIAGNOSIS & CLINICAL ASSESSMENT *(Fill in below or attach lab work)*

Primary Diagnosis Code & Condition: _____ **Joints Affected**: _____

Number of Tender Joints: _____ **Number of Swollen Joints**: _____ **Current Weight**: _____ **Date**: _____

☐ **New Therapy Induction |** Stop Date: _____ ☐ **Therapy Change |** Stop Date: _____

☐ **Therapy Continuation |** Stop Date: _____ **Weeks Completed**: ☐ 0 ☐ 2 ☐ 4 ☐ 6 **Allergies**: _____

ESR & Date: _____ **CRP & Date**: _____ **TB Results & Date**: _____

Actemra® (tocilizumab)

☐ 80 mg/4 mL Vial ☐ 162 mg Syringe
☐ 200 mg/10 mL Vial ☐ 400 mg/20 mL Vial
SIG: _____
QTY: _____ Refill: _____

Cimzia® (certolizumab pegol)

☐ 2 x 200 mg Kit ☐ Syringe ☐ Vial
SIG: _____
QTY: _____ Refill: _____

Remicade® (infliximab)

☐ 100 mg Vial **SIG:** _____
QTY: _____ Refill: _____

Rituxan® (rituximab)

☐ 100 mg Vial ☐ 500 mg Vial
SIG: _____QTY: _____Refill: _____

Xeljanz® / Xeljanz XR® (tofacitinib)

☐ 5 mg Tablet **SIG:** Take 5mg PO twice daily
QTY: 60 Refill: _____
☐ **XR** 11mg Tablet **SIG:** ☐ **14 day trial:**
Take 11mg PO once daily for 14 days (Qty 14)
☐ Take 11mg PO once daily (Qty 30)
QTY: Refill:

Enbrel® (etanercept)

☐ 25 mg Syringe ☐ 25 mg Vial
☐ 50 mg Syringe ☐ 50 mg SureClick Pen
SIG: _____QTY: Refill:

Kineret® (anakinra)

☐ 100 mg Syringe **SIG:** _____
QTY: _____ Refill: _____

Cosentyx® (secukinumab)

☐ Sensoready Pen ☐ Pre-filled syringe
☐ Initial – inject 150mg SQ on week 0, 1, 2, 3, and 4 (Qty 5). Maintenance – inject 150mg SQ every 4 weeks (Qty 1).
☐ Initial – inject 300mg SQ on week 0, 1, 2, 3, and 4 (Qty 10). Maintenance – inject 300mg SQ every 4 weeks (Qty 2).
QTY: _____ Refill: _____

Stelara® (ustekinumab)

PFS: ☐ 1 x 45mg/0.5mL ☐ 1 x 90mg/mL
☐ Inject 45mg SQ on Day 1 (<100kg)
☐ Inject 90mg SQ on Day 1 (>100kg)
☐ Inject 45mg SQ on Day 29 and every 12 weeks thereafter (<100kg)
☐ Inject 90mg SQ on Day 29 and every 12 weeks thereafter (>100kg)
QTY: _____ Refill: _____

Humira® (adalimumab)

☐ 10 mg Syringe ☐ 20 mg Syringe
☐ 40 mg Syringe ☐ 40 mg Pen
SIG: _____
QTY: _____ Refill: _____

Prolia® (denosumab)

☐ 60 mg PFS ☐ 60 mg Vial
SIG: _____
QTY: _____ Refill: _____
Bone Density Score: _____Date: _____

Orencia® (abatacept)

☐ (4) 125 mg Prefilled Syringe ☐ 250mg Vial
SIG: _____
QTY: Refill:

Otezla® (apremilast)

☐ Starter Kit ☐ 30mg tablet
SIG: _____
QTY: _____ Refill: _____

Simponi® (golimumab)

☐ 50 mg Syringe ☐ 50 mg Smartject
☐ 50 mg Vial (Aria)
SIG: _____
QTY: Refill:

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