US Bioservices
AmerisourceBergen

Rheumatology Referral Form (A-H)

Phone: (855) 751-7953
Fax: (888) 418-7246

Deliver to: ☐ Patient's Home ☐ Prescriber's Office ☐ Other:________ ☐ Hold shipment until notified by prescriber ☐ Anticipated Start Date:________

1. Patient Information

Last Name: ________ Home Phone: ________ Work/Mobile Phone: ________
First Name: ________ Home Address: ________
S.S. #: ________ Date of Birth: ________ City: ________ State: ________ Zip: ________
Guardian/Caregiver: ________ Sex: ☐ Male ☐ Female Height: ________ Weight: ________ ☐ lbs. ☐ kg.

2. Patient Insurance Information (Please fax front and back copy of all insurance cards - prescription & medical)

Medical Insurance: ________ Phone: ________ Prescription Card: ________ Phone: ________
Subscriber Name: ________ Policy #: ________ BIN/PCN: ________
Policy #: ________ Group #: ________ Medicare #: ________ Medicaid #: ________

3. Prescriber Information

Prescriber Name: ________ ☐ MD ☐ DO ☐ NP ☐ PA License #: ________ NPI #: ________ DEA #: ________
Practice Name: ________ Phone: ________ Fax: ________
Address: ________ Office Contact: ________ Phone: ________
City: ________ State: ________ Zip: ________ Collaborating Physician: ________

4. Diagnosis & Clinical Information (Please fax recent clinical notes, labs and tests, with the prescription to expedite the prior authorization)

Primary ICD-10: ________ Meds Tried & Failed: ________
Secondary ICD-10: ________ Concurrent Medications: ________
Allergies: ________ DMARDS: ________ NSAIDS: ________
Vaccination History: ________ Biologics: ________ Other: ________

5. Prescription Information (Ilaris, Otezla, Orencia, Simponi, Stelara, and Xeljanz are available on Rheumatology Referral Form I-Z)

Medication	Dose/Strength	Directions	Dispense	Refills
ACTEMRA®	☐ 162 mg/0.9 mL PFS	☐ **< 100 kg (220 lbs):** Inject 162 mg SC every other week ☐ **≥ 100 kg (220 lbs):** Inject 162 mg SC QW		
	☐ 80 mg/4mL SDV ☐ 200 mg/10 mL SDV ☐ 400 mg/20 mL SDV	☐ Infuse 4 mg/kg IV over 1 hour q4wks, increase to 8 mg/kg q4wks based on clinical response. Doses exceeding 800 mg per infusion are not recommended.		
BENLYSTA®	☐ 120 mg/5 mL SDV ☐ 400 mg/20 mL SDV ☐ 200 mg PFS ☐ 200 mg Autoinjector	☐ IV Infusion: Infuse 10 mg/kg IV (over 1 hour) at weeks 0,2, and 4 and then q4wks thereafter ☐ SubQ Administration: Inject 200 mg SC once weekly		
CIMZIA®	☐ 200 mg/mL PFS Kit ☐ 200 mg/mL Starter Kit ☐ 200 mg/mL Vial Kit	☐ Initial Dose: Inject 400 mg SC qw at weeks 0, 2 and 4 ☐ Maintenance Dose: Inject 200 mg SC once q4wks ☐ Maintenance Dose: Inject 400 mg SC once q4wks		
COSENTYX®	☐ 150 mg/mL PFS ☐ 150 mg/mL Sensoready® Pen	☐ Initial Dose: Inject 300 mg SC at weeks 0 - 4 ☐ Initial Dose: Inject 150 mg SC at weeks 0 - 4 ☐ Maintenance Dose: Inject 150 mg SC q4wks ☐ Maintenance Dose: Inject 300 mg SC q4wks		
ENBREL®	☐ 25 mg PFS ☐ 25 mg Vial ☐ 50 mg PFS ☐ 50 mg SureClick® Autoinjector	☐ Inject 50 mg SC qw ☐ Inject 0.8 mg/kg SC qw (max 50 mg per week if > 63 kg [138 lbs]) ☐ Inject 50 mg SC twice weekly for three months followed by 50 mg every week		
HUMIRA®	☐ 10 mg/0.1 mL PFS ☐ 10 mg/0.2 mL PFS ☐ 20 mg/0.2 mL PFS ☐ 20 mg/0.4 mL PFS ☐ 40 mg/0.4 mL PFS ☐ 40 mg/0.8 mL PFS ☐ 40 mg/0.4 mL Pen ☐ 40 mg/0.8 mL Pen	☐ **Rheumatoid Arthritis/Psoriatic Arthritis:** Inject 40 mg SC (one 40 mg Pen) every other week **Juvenile Idiopathic Arthritis:** ☐ **10 kg (22 lbs) to <15 kg (33 lbs):** 10 mg every other week ☐ **15 kg (33 lbs) to < 30 kg (66 lbs):** 20 mg every other week ☐ **≥ 30 kg (66 lbs):** 40 mg every other week		

Patient Support Programs: Please have patient sign and date to enroll in pharmaceutical company assisted patient support program.

Patient Signature ________ Date ____ / ____ / ____

Account Manager

Prescriber Authorization (No stamps. Signature and date must be completed in prescriber's handwriting. NY prescriptions must be submitted via e-script.)

I authorize US Bioservices Corporation to act as my representative and on behalf of myself and my patient to initiate any authorization processes from applicable health plans, if needed, including the submission of any necessary forms to such health plans.

Prescriber Signature-Substitution Permissible PRESCRIBER SIGNATURE REQUIRED. NO STAMPS. ________ Date ____ / ____ / ____

Prescriber Signature-Dispense as Written PRESCRIBER SIGNATURE REQUIRED. NO STAMPS. ________ Date ____ / ____ / ____