US Bioservices
AmerisourceBergen

Rheumatology Referral Form (I-Z)

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: _____ ☐ lb ☐ kg

2. Patient Insurance Information (Please fax front and back copy of all insurance cards - prescription and 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 and 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 (Actemra, Benlysta, Cimzia, Cosentyx, Enbrel, and Humira are available on the Rheumatology Referral Form A-H)

Medication	Dose / Strength	Directions	Dispense	Refills
ILARIS®	☐ 150 mg LYO SDV ☐ 150 mg/mL solution SDV	• ≥7.5 kg (16.5 lb): Inject 4 mg/kg (maximum of 300 mg) SC every 4 weeks		
KEVZARA®	☐ 150 mg/1.14 mL PFS ☐ 200 mg/1.14 mL PFS ☐ 150 mg/1.14 mL Pen ☐ 200 mg/1.14 mL Pen	☐ Inject 150 mg SC once every two weeks ☐ Inject 200 mg SC once every two weeks	**1**	
OLUMIANT®	☐ 2 mg tablet	• Take 2 mg PO once daily	**30**	
OTEZLA®	☐ 28 Day Starter Pack	• Day 1: Take 10 mg PO QAM • Day 2: Take 10 mg PO BID • Day 3: Take 10 mg PO QAM and 20 mg QPM • Day 4: Take 20 mg PO BID • Day 5: Take 20 mg PO QAM and 30 mg QPM • Day 6: and after: Take 30 mg PO BID	**1**	**0**
	☐ 30 mg tablet	• Take 30 mg PO twice daily	**60 Tablets**	
ORENCIA®	☐ 50 mg/0.4 mL PFS ☐ 87.5 mg/0.7 mL PFS ☐ 125 mg/mL PFS ☐ 125 mg/mL ClickJect™ Autoinjector	☐ 10 kg (22 lb) to < 25 kg (55 lb): Inject 50 mg SC once weekly ☐ 25 kg (55 lb) to < 50 kg (110 lb): Inject 87.5 mg SC once weekly ☐ 50 kg (110 lb): Inject 125 mg SC once weekly	**1 Box**	
RINVOQ™	☐ 15 mg XR tabs	• Take 15 mg PO once daily	**30 Tablets**	
SIMPONI ARIA®	☐ 50 mg/4 mL SDV	• Infuse 2 mg/kg IV over 30 minutes at weeks 0 and 4, then every 8 weeks		
SIMPONI®	☐ 50 mg/0.5 mL PFS ☐ 50 mg/0.5 mL Autoinjector	☐ Inject 50 mg SC once per month	**1**	
STELARA®	☐ 45 mg/0.5 mL PFS	☐ Initial Dose: Inject 45 mg SC at weeks 0 and 4	**2**	**0**
		☐ Maintenance Dose: Inject 45 mg SC q12weeks	**1**	
	☐ 90 mg/mL PFS	☐ Initial Dose: Inject 90 mg SC at weeks 0 and 4	**2**	**0**
		☐ Maintenance Dose: Inject 90 mg SC q12weeks	**1**	
TALTZ®	☐ 80 mg/mL Autoinjector	☐ Inital Dose: Inject 160 mg (two 80 mg injections) SC at week 0	**2**	**0**
	☐ 80 mg/mL PFS	☐ Maintenance Dose: Inject 80 mg SC every 4 weeks	**1**	
XELJANZ®	☐ 5 mg tabs ☐ 11 mg XR tabs	☐ Take 5 mg PO twice daily ☐ Take 11 mg PO daily		

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 _____ / _____ / _____