CEDRA

RHEUMATOLOGY
REFERRAL FORM

FAX: 888.889.7129
TOLL FREE: 844.233.7279
CEDRASPECIALTY.COM

PATIENT INFORMATION

Patient Name: DOB: Preferred Phone:

SSN#: Language: ☐ English ☐ Other

Address: Sex: ☐ Male ☐ Female Height: Weight: ☐ lbs ☐ kg

City: State: Zip: Known Allergies:

*** PLEASE FAX FRONT/BACK COPY OF PHARMACY BENEFIT CARD, MEDICAL INSURANCE CARD, NOTES, LABS & TESTS WITH THE PRESCRIPTION TO EXPEDITE PROCESSING ***

PRESCRIBER INFORMATION

Prescriber Name: DEA#: NPI#: Tax ID#:

Address: Phone: E-mail:

City: State: Zip: Key Contact: Phone: Fax:

STATUS UPDATE PREFERENCE: ☐ Phone ☐ Text ☐ Fax ☐ E-mail:

DIAGNOSIS/CLINICAL INFORMATION

☐ Rheumatoid Arthritis ☐ Ankylosing Spondylitis ☐ Juvenile RA (JIA) ☐ Psoriatic Arthritis ☐ Psoriasis ☐ Other: ICD-10 Code:

Severity index: ☐ Mild ☐ Moderate ☐ Severe

Has patient been treated previously for this condition? ☐ Yes ☐ No

Medication/therapy failed (length of therapy): Therapies:

Is patient currently on therapy? ☐ Yes ☐ No Type/Medications:

Will patient terminate current therapy upon start of new prescription? ☐ Yes ☐ No How long should the patient wait before starting the new drug therapy?

Other medications patient is currently taking including OTC medications with dosage and direction (or fax medication profile):

Which type of TB test has the patient received? ☐ PPD ☐ QFT-G Results:

PRESCRIPTION INFORMATION

MEDICATION	DOSE/STRENGTH	SIG	QTY.	REFILLS
☐ ACTEMRA®	☐ 162 mg/0.9ml PFS	☐ Inject 162 mg SC ONCE weekly. ☐ Inject 162 mg SC every OTHER week. ☐ Other		
☐ CIMZIA® Initial Dose ☐ CIMZIA® Maintenance Treatment	☐ 200 mg Starter Kit (6 syringes) ☐ 2 x 200 mg Prefilled Syringe	☐ Inject 400 mg SC once, then repeat at weeks 2 and 4. ☐ 200 mg SC ONCE every 2 weeks. ☐ 400 mg SC ONCE every 4 weeks.		
☐ ENBREL®	☐ 50 mg/ml SureClick™ Autoinjector ☐ 50 mg/ml Prefilled Syringe ☐ 25 mg Prefilled Syringe	☐ Inject 50mg SC ONCE weekly. ☐ Inject 25mg TWICE a week, 72 to 96 hours apart. ☐ Other		
☐ ENSTILAR®	☐ 60 Gram Package	☐ Shake well and apply to ONCE daily for up to 4 weeks. Rub in gently and wash hands after use. Do not use more than 60 grams every 4 days.		
☐ HUMIRA®	☐ 40 mg/0.8ml Pen ☐ 40 mg/0.8ml Prefilled Syringe	☐ Inject 40 mg SC every OTHER week. ☐ Inject 40 mg SC ONCE weekly.		
☐ KEVZARA®	☐ 150 mg/1.14 ml Prefilled Syringe ☐ 200 mg/1.14 ml Prefilled Syringe	☐ 200 mg once every two weeks administered as a subcutaneous injection.		
☐ METHOTREXATE®				
☐ OTEZLA®	☐ Starter RX ☐ 30 mg	☐ Starter Pak - Use as directed. ☐ TWICE daily.		
☐ ORENCIA®	☐ 125 mg/ml Prefilled Syringe (4 syringes) ☐ 125 mg/ml Prefilled ClickJect™	☐ Inject 125 mg SC ONCE weekly.		
☐ REMICADE® Wt:	☐ 100 mg Vial	☐ Rheumatoid Arthritis: In conjunction with methotrexate, 3 mg/kg at 0, 2 and 6 weeks, then every 8 weeks. ☐ Ankylosing Spondylitis 5 mg/kg at 0, 2 and 6 weeks, then every 6 weeks.		
☐ SIMPONI®	☐ 50 mg/0.5 ml Prefilled Syringe ☐ 50 mg/0.5 ml Autoinjector	☐ Inject 50 mg ONCE a month.		
☐ STELARA®	☐ 45 mg/0.5 ml Prefilled Syringe ☐ 45 mg/0.5 ml Single Use Vial ☐ 90 mg/ml Prefilled Syringe ☐ 90 mg/ml Single Use Vial	Psoriasis ☐ For patients weighing ≤100 kg (220 lbs), the recommended dose is 45 mg initially and 4 weeks later, followed by 45 mg every 12 weeks. ☐ For patients weighting > 100kg (220 lbs) the recommended dose is 90 mg initially and 4 weeks later, followed by 90 mg every 12 weeks. Psoriatic Arthritis ☐ The recommended dose is 45 mg initially and 4 weeks later, followed by 45 mg every 12 weeks. ☐ For patients with co-existent moderate-to-severe plaque psoriasis weighing >100 kg (220 lbs), the recommended dose is 90 mg initially and 4 weeks later, followed by 90 mg every 12 weeks.		
☐ XELJANZ® ☐ XELJANZ® XR	☐ 5 mg ☐ 11 mg	☐ 5 mg TWICE daily. ☐ 5 mg ONCE daily (recommended for patients with moderate and severe renal impairment and moderate hepatic impairment). NOTE: XELJANZ® in patients with severe hepatic impairment is not recommended. ☐ 11 mg ONCE daily. NOTE: XELJANZ® XR in patients with severe hepatic impairment is not recommended.		
☐				

Date Medication Needed: **Deliver To: ☐ Patient Home ☐ MD Office**

Prescriber Signature: (Please sign and date below.)

Your signature authorizes Cedra Pharmacy to act on your behalf to obtain prior authorization for the prescribed medications. We will also pursue available copay and financial assistance on behalf of your patients.

Substitution Permissible Date Dispense as written "DAW" Date

SUBMIT FORM CLEAR FORM