RHEUMATOLOGY REFERRAL FORM A-C

Albertsons Companies Specialty Care | MedCart Specialty Pharmacy | Jewel-Osco | Albertsons | Safeway | Vons | Acme | Shaw's | Star Market | Pavilions | Carrs | Randalls | Tom Thumb

Patient Information

Patient Name: _____ DOB: _____ Sex: ☐ M ☐ F
Phone: _____ Cell Phone: _____ Email Address: _____
Address: _____ City: _____ State: _____ Zip: _____
ICD-10 Diagnosis Code: _____ Diagnosis: _____
Allergies (please note reaction): _____ ☐ Latex
Current Medications: (list here or attach a medication list): _____
_____
Comorbidities: (list here or attach a list): _____

Prescription Information

INSURANCE INFORMATION – FAX COPY OF PATIENT'S INSURANCE CARD – BOTH SIDES

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Actemra (tocilizumab)	☐ 162mg/0.9mL Prefilled Syringe ☐ 162mg/09mL Actemra ACTPen	☐ Inject 162mg subcutaneously every other week. ☐ Inject 162mg subcutaneously once a week.	☐ 2 syringes/pens ☐ 4 syringes/pens ☐ _____ syringes/pens	
☐ Cimzia (certolizumab)	☐ Starter Kit 200mg/mL Prefilled Syringe ☐ 200mg/mL Prefilled Syringe	☐ Loading Dose: Inject 400mg (2 syringes) subcutaneously at weeks 0, 2 and 4. ☐ Maintenance Dose: Inject 400mg (2 syringes) subcutaneously every 4 weeks. ☐ Maintenance Dose: Inject 200mg (1 syringe) subcutaneously every 2 weeks.	1 kit (6 syringes) ☐ 2 syringes ☐ 6 syringes	
☐ Cosentyx (secukinumab)	☐ 150mg Sensoready Pen ☐ 150mg Prefilled Syringe	☐ Loading Dose: Inject 150mg subcutaneously once weekly at weeks 0, 1, 2, 3, and 4. ☐ Loading Dose: Inject 300mg (2 injections of 150mg) subcutaneously once weekly at weeks 0, 1, 2, 3, and 4. ☐ Maintenance dose: Starting at week 4, inject 150mg subcutaneously every 4 weeks. ☐ Maintenance dose: Starting at week 4, inject 300mg (2 injections of 150mg) subcutaneously every 4 weeks.	☐ 4 syringes/pens ☐ 8 syringes/pens ☐ 1 syringe/pen ☐ 2 syringes/pens ☐ _____ syringes/pens	

Treatment History: ☐ New to Therapy ☐ Continuation of Therapy

Hepatitis B Screening Results: ☐ HBsAg: _____ ☐ Anti-HBs: _____ ☐ Anti-HBc: _____
If applicable, has treatment been initiated? ☐ Yes ☐ No
Tuberculosis Assessment Date: ☐ Negative ☐ Active TB ☐ Latent TB ☐ History of active or latent TB
If history of active or latent TB: _____ Adequate treatment is confirmed: ☐ Yes ☐ No
History of Irritable Bowel Disease: ☐ Yes ☐ No

Prescriber Information

Prescriber Name: _____
State License #: _____ DEA #: _____ NPI: _____
Additional Contact Person Name: _____
Group or Hospital: _____ Phone: _____
Fax: _____ Email Address: _____
Address: _____ City: _____ State: _____ Zip: _____

Prescriber Signature: _____ _____ _____
Product Substitution Permitted | Dispensed as Written | Date

The prescriber is to comply with state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.

Delivery Information

☐ Ship to Patient ☐ Ship to Prescriber/Clinic ☐ Pick up at Albertsons Companies Pharmacy Date Medication Needed: _____

RHEUMATOLOGY REFERRAL FORM D-H

Albertsons Companies Specialty Care | MedCart Specialty Pharmacy | Jewel-Osco | Albertsons | Safeway | Vons | Acme | Shaw's | Star Market | Pavilions | Carrs | Randalls | Tom Thumb

Patient Information

Patient Name: _____ DOB: _____ Sex: ☐ M ☐ F

Phone: _____ Cell Phone: _____ Email Address: _____

Address: _____ City: _____ State: _____ Zip: _____

ICD-10 Diagnosis Code: _____ Diagnosis: _____

Allergies (please note reaction): _____ ☐ Latex

Current Medications: (list here or attach a medication list): _____

_____

Comorbidities: (list here or attach a list): _____

Prescription Information

INSURANCE INFORMATION – FAX COPY OF PATIENT'S INSURANCE CARD – BOTH SIDES

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Enbrel (etanercept)	☐ 50mg/mL Sureclick Auto-injector ☐ 50mg/mL Prefilled Syringe ☐ 50mg/mL Enbrel Mini	☐ Inject 50mg subcutaneously once a week.	4 syringes/pens	
	☐ 25mg/0.5mL Prefilled Syringe ☐ 25mg Vial	☐ Inject 25mg subcutaneously twice a week.	8 syringes/vials	
☐ Humira (adalimumab) Patient weight: _____ kg	10kg to < 15kg ☐ 10mg/0.1 mL Citrate-free Prefilled Syringe ☐ 10mg/0.2 mL Prefilled Syringe	☐ Inject 10mg subcutaneously every OTHER week.	☐ 2 syringes/pens ☐ 4 syringes/pens	
	15kg to < 30kg ☐ 20mg/0.2 mL Citrate-free Prefilled Syringe ☐ 20mg/0.4 mL Prefilled Syringe	☐ Inject 20mg subcutaneously every OTHER week.		
	≥ 30kg ☐ 40mg/0.4 mL Citrate-free Pen ☐ 40mg/0.8 mL Pen ☐ 40mg/0.4 mL Citrate-free Prefilled Syringe ☐ 40mg/0.8 mL Prefilled Syringe	☐ Inject 40mg subcutaneously every OTHER week. ☐ Inject 40mg subcutaneously every week.		

Treatment History: ☐ New to Therapy ☐ Continuation of Therapy

Hepatitis B Screening Results: ☐ HBsAg: _____ ☐ Anti-HBs: _____ ☐ Anti-HBc: _____

If applicable, has treatment been initiated? ☐ Yes ☐ No

Tuberculosis Assessment Date: ☐ Negative ☐ Active TB ☐ Latent TB ☐ History of active or latent TB

If history of active or latent TB: _____ Adequate treatment is confirmed: ☐ Yes ☐ No

History of Irritable Bowel Disease: ☐ Yes ☐ No

Prescriber Information

Prescriber Name: _____

State License #: _____ DEA #: _____ NPI: _____

Additional Contact Person Name: _____

Group or Hospital: _____ Phone: _____

Fax: _____ Email Address: _____

Address: _____ City: _____ State: _____ Zip: _____

Prescriber Signature: _____ _____ _____

Product Substitution Permitted | Dispensed as Written | Date

The prescriber is to comply with state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.

Delivery Information

☐ Ship to Patient ☐ Ship to Prescriber/Clinic ☐ Pick up at Albertsons Companies Pharmacy Date Medication Needed: _____

RHEUMATOLOGY REFERRAL FORM I-N

Albertsons Companies Specialty Care | MedCart Specialty Pharmacy | Jewel-Osco | Albertsons | Safeway | Vons | Acme | Shaw's | Star Market | Pavilions | Carrs | Randalls | Tom Thumb

Patient Information

Patient Name: _____ DOB: _____ Sex: ☐ M ☐ F

Phone: _____ Cell Phone: _____ Email Address: _____

Address: _____ City: _____ State: _____ Zip: _____

ICD-10 Diagnosis Code: _____ Diagnosis: _____

Allergies (please note reaction): _____ ☐ Latex

Current Medications: (list here or attach a medication list): _____

_____

Comorbidities: (list here or attach a list): _____

Prescription Information

INSURANCE INFORMATION – FAX COPY OF PATIENT'S INSURANCE CARD – BOTH SIDES

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Kevzara®	☐ 150mg/1.14mL Pen ☐ 150mg/1.14mL Prefilled Syringe ☐ 200mg/1.14mL Pen ☐ 200mg/1.14mL Prefilled Syringe	☐ Inject 200mg subcutaneously every two weeks. ☐ Inject 150mg subcutaneously every two weeks.	2 syringes/pens	
☐ Kineret (anakinra)	100mg/0.67mL Prefilled Syringe	Inject 100mg subcutaneously every 24 hours.	28 syringes	

Treatment History: ☐ New to Therapy ☐ Continuation of Therapy

Hepatitis B Screening Results: ☐ HBsAg: _____ ☐ Anti-HBs: _____ ☐ Anti-HBc: _____

If applicable, has treatment been initiated? ☐ Yes ☐ No

Tuberculosis Assessment Date: ☐ Negative ☐ Active TB ☐ Latent TB ☐ History of active or latent TB

If history of active or latent TB: _____ Adequate treatment is confirmed: ☐ Yes ☐ No

History of Irritable Bowel Disease: ☐ Yes ☐ No

Prescriber Information

Prescriber Name: _____

State License #: _____ DEA #: _____ NPI: _____

Additional Contact Person Name: _____

Group or Hospital: _____ Phone: _____

Fax: _____ Email Address: _____

Address: _____ City: _____ State: _____ Zip: _____

Prescriber Signature: _____ _____ _____

Product Substitution Permitted | Dispensed as Written | Date

The prescriber is to comply with state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.

Delivery Information

☐ Ship to Patient ☐ Ship to Prescriber/Clinic ☐ Pick up at Albertsons Companies Pharmacy Date Medication Needed: _____

RHEUMATOLOGY REFERRAL FORM O

Albertsons Companies Specialty Care | MedCart Specialty Pharmacy | Jewel Osco | Albertsons | Safeway | Vons | Acme | Shaw's | Star Market | Pavilions | Carrs | Randalls | Tom Thumb

Patient Information

Patient Name: _____ DOB: _____ Sex: ☐ M ☐ F
Phone: _____ Cell Phone: _____ Email Address: _____
Address: _____ City: _____ State: _____ Zip: _____
ICD-10 Diagnosis Code: _____ Diagnosis: _____
Allergies (please note reaction): _____ ☐ Latex
Current Medications: (list here or attach a medication list): _____
_____
Comorbidities: (list here or attach a list): _____

Prescription Information

INSURANCE INFORMATION – FAX COPY OF PATIENT'S INSURANCE CARD – BOTH SIDES

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Olumiant®	2mg Tablets	Take one tablet by mouth once daily.	30 tablets	
☐ Orencia (abatacept)	☐ 250mg Vial (IV use only)	☐ Loading Dose: Inject _____mg via intravenous infusion at 0, 2 and 4 weeks.	3 vials	
		☐ Inject _____mg via intravenous infusion every 4 weeks.	___ vials	
	☐ 125mg/mL Prefilled Syringe ☐ 125mg/mL Auto-injector	☐ Adults and children ≥ 50 kg: Inject 125mg subcutaneously once weekly.	4 syringes/ autoinjectors	
☐ Otrexup (methotrexate)	☐ 7.5mg/0.4mL Auto-injector ☐ 10mg/0.4mL Auto-injector ☐ 12.5mg/0.4mL Auto-injector ☐ 15mg/0.4mL Auto-injector ☐ 17.5mg/0.4mL Auto-injector ☐ 20mg/0.4mL Auto-injector ☐ 22.5mg/0.4mL Auto-injector ☐ 25mg/0.4mL Auto-injector	Inject one autoinjector subcutaneously once weekly.	4 autoinjectors	

Treatment History: ☐ New to Therapy ☐ Continuation of Therapy

Hepatitis B Screening Results: ☐ HBsAg: _____ ☐ Anti-HBs: _____ ☐ Anti-HBc: _____
If applicable, has treatment been initiated? ☐ Yes ☐ No
Tuberculosis Assessment Date: ☐ Negative ☐ Active TB ☐ Latent TB ☐ History of active or latent TB
If history of active or latent TB: _____ Adequate treatment is confirmed: ☐ Yes ☐ No
History of Irritable Bowel Disease: ☐ Yes ☐ No

Prescriber Information

Prescriber Name: _____
State License #: _____ DEA #: _____ NPI: _____
Additional Contact Person Name: _____
Group or Hospital: _____ Phone: _____
Fax: _____ Email Address: _____
Address: _____ City: _____ State: _____ Zip: _____

Prescriber Signature: _____ _____ _____
Product Substitution Permitted | Dispensed as Written | Date

The prescriber is to comply with state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.

Delivery Information

☐ Ship to Patient ☐ Ship to Prescriber/Clinic ☐ Pick up at Albertsons Companies Pharmacy Date Medication Needed: _____

RHEUMATOLOGY REFERRAL FORM P-R

Albertsons Companies Specialty Care | MedCart Specialty Pharmacy | Jewel Osco | Albertsons | Safeway | Vons | Acme | Shaw's | Star Market | Pavilions | Carrs | Randalls | Tom Thumb

Patient Information

Patient Name: _____ DOB: _____ Sex: ☐ M ☐ F
Phone: _____ Cell Phone: _____ Email Address: _____
Address: _____ City: _____ State: _____ Zip: _____
ICD-10 Diagnosis Code: _____ Diagnosis: _____
Allergies (please note reaction): _____ ☐ Latex
Current Medications: (list here or attach a medication list): _____
_____
Comorbidities: (list here or attach a list): _____

Prescription Information

INSURANCE INFORMATION – FAX COPY OF PATIENT'S INSURANCE CARD – BOTH SIDES

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Rasuvo (methotrexate)	☐ 7.5mg/0.15 Auto-injector ☐ 10mg/0.2mL Auto-injector ☐ 12.5mg/0.25mL Auto-injector ☐ 15mg/0.3mL Auto-injector ☐ 17.5mg/0.35mL Auto-injector ☐ 20mg/0.4mL Auto-injector ☐ 22.5 mg/0.45mL Auto-injector ☐ 25mg/0.5mL Auto-injector ☐ 27.5mg/0.55mL Auto-injector ☐ 30mg/0.6mL Auto-injector	Inject one autoinjector subcutaneously once weekly.	4 autoinjectors	
☐ Remicade (infliximab) ☐ Inflectra (infliximab-dyyb) Patient weight: _____ kg	100mg Vial	☐ Loading Dose: Administer _____mg (at _____ mg/kg) intravenously at 0, 2 and 6 weeks.	____vials	
		☐ Maintenance Dose: Administer _____mg (at _____mg/kg) intravenously every_____weeks.	____vials	

Treatment History: ☐ New to Therapy ☐ Continuation of Therapy

Hepatitis B Screening Results: ☐ HBsAg: _____ ☐ Anti-HBs: _____ ☐ Anti-HBc: _____
If applicable, has treatment been initiated? ☐ Yes ☐ No
Tuberculosis Assessment Date: ☐ Negative ☐ Active TB ☐ Latent TB ☐ History of active or latent TB
If history of active or latent TB: _____ Adequate treatment is confirmed: ☐ Yes ☐ No
History of Irritable Bowel Disease: ☐ Yes ☐ No

Prescriber Information

Prescriber Name: _____
State License #: _____ DEA #: _____ NPI: _____
Additional Contact Person Name: _____
Group or Hospital: _____ Phone: _____
Fax: _____ Email Address: _____
Address: _____ City: _____ State: _____ Zip: _____

Prescriber Signature: _____ _____ _____
Product Substitution Permitted | Dispensed as Written | Date

The prescriber is to comply with state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.

Delivery Information

☐ Ship to Patient ☐ Ship to Prescriber/Clinic ☐ Pick up at Albertsons Companies Pharmacy Date Medication Needed: _____

RHEUMATOLOGY REFERRAL FORM S-Z

Albertsons Companies Specialty Care | MedCart Specialty Pharmacy | Jewel Osco | Albertsons | Safeway | Vons | Acme | Shaws | Star Market | Pavilions | Carrs | Randalls | Tom Thumb

Patient Information

Patient Name: _____ DOB: _____ Sex: ☐ M ☐ F
Phone: _____ Cell Phone: _____ Email Address: _____
Address: _____ City: _____ State: _____ Zip: _____
ICD-10 Diagnosis Code: _____ Diagnosis: _____
Allergies (please note reaction): _____ ☐ Latex
Current Medications: (list here or attach a medication list): _____
_____
Comorbidities: (list here or attach a list): _____

Prescription Information

INSURANCE INFORMATION – FAX COPY OF PATIENT'S INSURANCE CARD – BOTH SIDES

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Simponi (golimumab)	☐ 50mg/0.5mL SmartJect Auto-injector ☐ 50mg/0.5mL Prefilled Syringe	Inject 50mg subcutaneously once monthly.	☐ 1 syringe/pen ☐ 3 syringes/pens	
☐ Taltz (ixekizumab)	☐ 80mg/mL Auto-injector ☐ 80mg/mL Prefilled Syringe	☐ Inject 160mg subcutaneously at weeks 2, 4, 6, 8, 10 and 12; then inject 80mg subcutaneously every 4 weeks. ☐ Inject 160mg subcutaneously once, followed by 80mg subcutaneously every 4 weeks.	☐ 4 syringes/pens	2
		☐ Inject 80mg subcutaneously every 4 weeks.	☐ 1 syringe/pen ☐ 2 syringes/pens	
☐ Xeljanz (tofacitinib)	☐ 5mg Tablet	☐ Take 1 tablet by mouth twice daily.	60 tablets	
		☐ Take 1 tablet by mouth once a day (renal/hepatic impairment).	30 tablets	
☐ Xeljanz XR (tofacitinib)	☐ 11mg XR Tablet	Take 1 tablet by mouth once daily.	30 tablets	
Other Medication Name:				

Treatment History: ☐ New to Therapy ☐ Continuation of Therapy

Hepatitis B Screening Results: ☐ HBsAg: _____ ☐ Anti-HBs: _____ ☐ Anti-HBc: _____
If applicable, has treatment been initiated? ☐ Yes ☐ No
Tuberculosis Assessment Date: ☐ Negative ☐ Active TB ☐ Latent TB ☐ History of active or latent TB
If history of active or latent TB: _____ Adequate treatment is confirmed: ☐ Yes ☐ No
History of Irritable Bowel Disease: ☐ Yes ☐ No

Prescriber Information

Prescriber Name: _____
State License #: _____ DEA #: _____ NPI: _____
Additional Contact Person Name: _____
Group or Hospital: _____ Phone: _____
Fax: _____ Email Address: _____
Address: _____ City: _____ State: _____ Zip: _____

Prescriber Signature: _____ _____ _____
Product Substitution Permitted | Dispensed as Written | Date

The prescriber is to comply with state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.

Delivery Information

☐ Ship to Patient ☐ Ship to Prescriber/Clinic ☐ Pick up at Albertsons Companies Pharmacy Date Medication Needed: _____