Rheumatology Referral Form		SUPERIO	SUPERIOR BIOLOGICS			
Date:		Fax Referral	eferral To: 877-521-5353			ICS
		Phone: 8	800-521-3949			
	Patient Information		Pr	 escriber Informati	ion	
Patient Name:			Prescriber Name:			
Address:			Address:			
City, State, Zip:		City, State, Zip:				
Home Phone:						
Cell Phone:			Fax: DEA:NPI#:			
DOB: Gender: □ M □ F			Contact Person:			
Geriaer.		Insurance I	nformation			
Primary Insura	ance:		D#:	Group:		
	surance:		D#:			
Prescription Ca	rd: ID#:	E	BIN#: PCN#: _			
	Clinical Informatio	n (Please fax all	pertinent clinical and	lab information)		
☐ M06.9 (Rheu	ımatoid Arthritis) 🗆 M08.0 (Juven	ile Idiopathic Arthritis) □ L40.59 (Psoriatic Arth	nritis) 🗆 L40.54 (Psoria	itic Juvenile A	Arthritis)
☐ M45.9 (Anky	losing Spondylitis) 🗆 M32.9 (Sys	temic Lupus Erythem	atosis)	r:		
Diagnosis Date						
	Diagnosis and C	Clinical Assessme	ent (Fill in below or at	tach lab work)		
	llen Joints: Current W	-				
	/ Induction Stop Date:					
☐ Therapy Continuation Stop Date: ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐						
l Δllerαies:						
	ate (Please provide copy of result):					
TB Results & Da	ate (Please provide copy of result):					
TB Results & Da					Qty	Refills
TB Results & Da ☐ Bone Density	ate (Please provide copy of result): y Score & Date (Please provide a control of the control of	copy of results): L	Directions lkg Inject 162mg/0.9mL SC	every 2 weeks		Refills
TB Results & Da ☐ Bone Density Medication	ate (Please provide copy of result): Score & Date (Please provide a compose Strength)	copy of results): L	Directions	every 2 weeks		Refills
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TB Results & Da □ Bone Density Medication Actemra	ate (Please provide copy of result): / Score & Date (Please provide a control of the control of	L	Directions lkg Inject 162mg/0.9mL SC lkg Inject 162mg/0.9mL SC larter Dose: Infuse 10mg/l ses aintenance: Inject 10mg/l	c every 2 weeks c every week kg every 2 weeks for kg every 4 weeks		Refills
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TB Results & Da Bone Density Medication Actemra Benlysta Cimzia Cosentyx Enbrel	ate (Please provide copy of result): / Score & Date (Please provide a compose Strength) Prefilled Syringe 162mg/0.9m Auto Injector 162mg/0.9mL 10mg/kg 200mg PFS 200mg Autoinjector Starter Kit Syringe Via 150mg Sensoready Pen 300mg Sensoready Pen 300mg Syringe 50mg Sure Compose 50mg Sure Compose Mini 50mg/mL 105mg/1.17mL 600mcg/2.4mL PFS 10mg Syringe	copy of results): L	Directions lkg Inject 162mg/0.9mL SC larter Dose: Infuse 10mg/lkg let 200mg SC once weekly lister first SC dose 1-4 were repose: Inject 400mg SC letenance Dose: Inject 200mg SC letenance Dose: Inject 400mg SC letenance: Inject 150mg SC letenance: Inject 300mg SC	c every 2 weeks c every week kg every 2 weeks for kg every 4 weeks (if switching from IV eks after last IV dose) on week 0, 2, and 4 ng SC every 2 weeks ng SC once a month on week 0, 1, 2, 3, every 4 weeks on week 0, 1, 2, 3, every 4 weeks on week 0, 1, 2, 3, every 4 weeks on week 0, 1, 2, 3, every 4 weeks (if x kg) SC once daily ek (10 to <15kg)	Qty 5 1 10 2	Refills
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DAW (Dispense as Written) Date:

Prescriber Signature:

Rheumat	ology Referral Form	SUPERIOR BIOLOGICS Fax Referral To: 877-521-5353 Phone: 800-521-3949		SIII	PFRI	
Date:				BIO	PERIOR LOGICS	
	Patient Information	n	Pres	scriber Information	n	
Patient Name:			Prescriber Name:			
):					
Home Phone:						
Cell Phone:		Fax:				
DOB:			DEA:NPI #:			
Gender: □ M	l □F		Contact Person:			
		Insuranc	ce Information			
Primary Insura	nnce:		ID#:	Group:		
	urance:					
Prescription Ca			BIN#: PCN#:	•		
Clinical Information (Please fax all pertinent clinical and lab information) M06.9 (Rheumatoid Arthritis) M08.0 (Juvenile Idiopathic Arthritis) L40.59 (Psoriatic Arthritis) L40.54 (Psoriatic Juvenile Arthritis) M45.9 (Ankylosing Spondylitis) M32.9 (Systemic Lupus Erythematosis) Diagnosis Date:						
1 · · · · · · · · · · · · · · · · · · ·			ment (Fill in below or atta			
			of Tender Joints: C			
			Current Height:Date: _			
□ New Therapy Induction Stop Date: □ Therapy Change Stop Date: □ Therapy Continuation Stop Date: □ Weeks Completed: □ 0 □ 2 □ 4 □ 6					□ 6	
	Titilidation Stop Date.		\(\text{Veeks Completes}\)	eled. 🗆 0 🗆 2	□ 4	□ 0
	ate (Please provide copy of resul					
	Score & Date (Please provide a	,				
Medication	Dose Strength		Directions		Qty	Refills
Kevzara	☐ 150mg/1.14mL PFS ☐ 200)mg/1.14mL Pen	☐ Inject 200mg SC once every ☐ Other:	2 weeks		
Krystexxa	□ 8mg/mL		☐ Infuse 8mg in 250mL of NS once every 2 weeks	over 120 minutes		
Olumiant	☐ 2mg Tablet ☐ 1	mg Tablet	\square Take one tablet PO daily			
Orencia	☐ 125mg Pen ☐ 2 ☐ 125mg Pen Syringe	50mg Vial	□ IV Dosage: Infuser then every 4 weeks there: □ SC Dosage: Inject 125mg SC			
Otezla	☐ Starter Pack ☐ 3	0mg Tablet	☐ Starter Pack: Use as directed ☐ Maintenance Dose: Take or			
Prolia	☐ 60mg PFS		☐ Inject 1 syringe SC every 6 n	nonths		
☐ Avsola ☐ Inflectra ☐ Remicade ☐ Renflexis	□ 100mg Vial		☐ Loading Dose: Infuse 5mg/k☐ Maintenance Dose: Infuse weeks			
Rinvoq	□ 15mg		☐ Take 1 tablet PO daily			
☐ Rituxan	☐ 100mg Vial ☐ 5	00mg Vial	☐ Infuse 1000mg on day 1 and	d day 15		

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DAW (Dispense as Written) Date:

Prescriber Signature:

Rheumatology Referral Form **SUPERIOR BIOLOGICS** SUPERIOR Fax Referral To: 877-521-5353 Date: Phone: 800-521-3949 **Patient Information Prescriber Information** Patient Name: Prescriber Name: _____ Address: ___ Address: City, State, Zip: City, State, Zip: Home Phone: Phone: Cell Phone: Fax: DOB: _____ DEA: NPI #: Gender: □ M □ F Contact Person: Insurance Information Primary Insurance: ID#: Group: ID#: _____ Group: ___ BIN#: ____ PCN#: ___ Group: __ Secondary Insurance: _____ Prescription Card: _____ ID#: ____ Clinical Information (Please fax all pertinent clinical and lab information) □ M06.9 (Rheumatoid Arthritis) □ M08.0 (Juvenile Idiopathic Arthritis) □ L40.59 (Psoriatic Arthritis) □ L40.54 (Psoriatic Juvenile Arthritis) ☐ M45.9 (Ankylosing Spondylitis) ☐ M32.9 (Systemic Lupus Erythematosis) ☐ Other: Diagnosis Date: Diagnosis and Clinical Assessment (Fill in below or attach lab work) Joints Affected: Number of Tender Joints: CRP: Date: Number of Swollen Joints: Current Weight: Current Height: Date: ESR: Date: Joints Affected: □ New Therapy Induction | Stop Date: □ Therapy Change | Stop Date ☐ Therapy Continuation | Stop Date: ☐ ☐ Weeks Completed: ☐ ☐ ☐ 2 ☐ ☐ 4 □ 6 Allergies: ___ TB Results & Date (Please provide copy of result): ☐ Bone Density Score & Date (Please provide a copy of results): ____ Dose Strength Medication **Directions** Qty Refills Simponi/Simponi Aria Simponi: Simponi: ☐ SmartJect 50mg/0.5mL ☐ Inject 50mg SC once per month Simponi Aria: ☐ Infuse _____ mg(2mg/kg) IV over 30 ☐ 50mg/0.5mL PFS Simponi Aria: minutes at 0 and 4 weeks, then every 8 weeks ☐ 50mg/4mL Vial ☐ 45mg/0.5mL PFS ☐ Inject 45mg SC on Day 1 (<100kg) Stelara ☐ Inject 90mg SC on day 1 (>100kg) □ 90mg/mL PFS ☐ Inject 45mg SC on Day 29 and every 12 weeks thereafter (<100kg) ☐ Inject 90mg SC on Day 29 and every 12 weeks thereafter (>100kg) ☐ Initial Dose: Inject 150mg SC weeks 0, and 4 ☐ 150 mg/mL in each single-Skyrizi dose prefilled pen ☐ Maintenance Dose: Inject 150mg SC every 12 □ 90 mg/mL in each singleweeks dose prefilled syringe ☐ 150 mg/mL in each singledose prefilled syringe ☐ Starter Dose: Inject 160mg SC on Day 1 Taltz ☐ 80mg/mL AutoInjector ☐ Maintenance: Inject 80mg SC every 4 weeks □100mg PFS ☐ Inject SubQ 100 mg at weeks 0, 4, and then Tremfya □ 100mg One-Press every 8 weeks thereafter. autoinjector ☐ 80mcg/0.04mL ☐ Inject 80mcg SC once daily into periumbilical ☐ 1-Prefilled Pen Tymlos

Prescriber Signature: _____ DAW (Dispense as Written) Date: ____

☐ Take one tablet twice daily

☐ Take one tablet once daily

Xeljanz:

Xeljanz XR:

Xeljanz/XR

Xeljanz: ☐ 5mg Tablet

Xeljanz XR:

☐ 11mg Tablet

region; give with supplemental calcium and vitamin D if dietary intake is not adequate

□ 60

□ 30

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