Rheumatology Referral Form	SUPERIOR BIOLOGICS Fax Referral To: 877-521-5353 Phone: 800-521-3949	SUPERIOR BIOLOGICS
Date: _____		

Patient Information

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Cell Phone: _____
DOB: _____
Gender: ☐ M ☐ F

Prescriber Information

Prescriber Name: _____
Address: _____
City, State, Zip: _____
Phone: _____
Fax: _____
DEA: _____ NPI #: _____
Contact Person: _____

Insurance Information

Primary Insurance: _____ ID#: _____ Group: _____
Secondary Insurance: _____ ID#: _____ Group: _____
Prescription Card: _____ ID#: _____ BIN#: _____ PCN#: _____ Group: _____

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: _____
☐ New Therapy Induction | Stop Date: _____ ☐ Therapy Change | Stop Date: _____
☐ Therapy Continuation | Stop Date: _____ ☐ Weeks Completed: ☐0 ☐ 2 ☐ 4 ☐ 6
Allergies: _____
TB Results & Date (Please provide copy of result): _____
☐ Bone Density Score & Date (Please provide a copy of results): _____

Medication	Dose Strength	Directions	Qty	Refills
Actemra	☐ Prefilled Syringe 162mg/0.9mL ☐ Auto Injector 162mg/0.9mL	☐ <100kg Inject 162mg/0.9mL SC every 2 weeks ☐ >100kg Inject 162mg/0.9mL SC every week		
Benlysta	☐ 10mg/kg ☐ 200mg PFS ☐ 200mg Autoinjector	☐ **IV Starter Dose:** Infuse 10mg/kg every 2 weeks for 3 doses ☐ **IV Maintenance:** Inject 10mg/kg every 4 weeks ☐ Inject 200mg SC once weekly (if switching from IV administer first SC dose 1-4 weeks after last IV dose)		
Cimzia	☐ Starter Kit ☐ Syringe ☐ Vial	☐ **Starter Dose:** Inject 400mg SC on week 0, 2, and 4 ☐ **Maintenance Dose:** Inject 200mg SC every 2 weeks ☐ **Maintenance Dose:** Inject 400mg SC once a month		
Cosentyx	☐ 150mg Sensoready Pen ☐ 300mg Sensoready Pen	☐ **Starter Dose:** Inject 150mg SC on week 0, 1, 2, 3, and 4 ☐ **Maintenance:** Inject 150mg SC every 4 weeks ☐ **Starter Dose:** Inject 300mg SC on week 0, 1, 2, 3, and 4 ☐ **Maintenance:** Inject 300mg SC every 4 weeks	☐ 5 ☐ 1 ☐ 10 ☐ 2	
Enbrel	☐ 25mg Syringe ☐ 0.25mg Vial ☐ 50mg Syringe ☐ 50mg SureClick Pen ☐ Mini 50mg/mL	☐ Inject 50mg SC every week ☐ Inject _____ mg(0.8mg/kg x_____ kg) SC every week		
Evenity	☐ 105mg/1.17mL	☐ Inject 2 syringes (105mg each) for total dose of 210mg SQ once monthly	☐ 2	
Forteo	☐ 600mcg/2.4mL PFS	☐ **Maintenance:** Inject 20mcg SC once daily	☐ 1	
☐ Humira ☐ Adalimumab *(biosimilar)*	☐ 10mg Syringe ☐ 20mg Syringe ☐ 40mg/0.4mL Syringe ☐ 40mg/0.4mL Pen	☐ Inject 10mg SC every other week (10 to <15kg) ☐ Inject 20mg SC every other week (15 to <30kg) ☐ Inject 40mg SC every other week (30kg) ☐ Inject 40mg SC once weekly		

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

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Date: _____		

Patient Information

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Cell Phone: _____
DOB: _____
Gender: ☐ M ☐ F

Prescriber Information

Prescriber Name: _____
Address: _____
City, State, Zip: _____
Phone: _____
Fax: _____
DEA: _____ NPI #: _____
Contact Person: _____

Insurance Information

Primary Insurance: _____ ID#: _____ Group: _____
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Clinical Information (Please fax all pertinent clinical and lab information)

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☐ New Therapy Induction | Stop Date: _____ ☐ Therapy Change | Stop Date: _____
☐ Therapy Continuation | Stop Date: _____ ☐ Weeks Completed: ☐0 ☐ 2 ☐ 4 ☐ 6
Allergies: _____
TB Results & Date (Please provide copy of result): _____
☐ Bone Density Score & Date (Please provide a copy of results): _____

Medication	Dose Strength	Directions	Qty	Refills
Kevzara	☐ 150mg/1.14mL PFS ☐ 200mg/1.14mL Pen	☐ Inject 200mg SC once every 2 weeks ☐ Other:		
Krystexxa	☐ 8mg/mL	☐ Infuse 8mg in 250mL of NS over 120 minutes once every 2 weeks		
Olumiant	☐ 2mg Tablet ☐ 1mg Tablet	☐ Take one tablet PO daily		
Orencia	☐ 125mg Pen ☐ 250mg Vial ☐ 125mg Pen Syringe	☐ **IV Dosage:** Infuse ____mg at weeks 0, 2, 4 then every 4 weeks thereafter ☐ **SC Dosage:** Inject 125mg SC once a week		
Otezla	☐ Starter Pack ☐ 30mg Tablet	☐ **Starter Pack:** Use as directed ☐ **Maintenance Dose:** Take one tablet PO BID		
Prolia	☐ 60mg PFS	☐ Inject 1 syringe SC every 6 months		
☐ Avsola ☐ Inflectra ☐ Remicade ☐ Renflexis	☐ 100mg Vial	☐ **Loading Dose:** Infuse 5mg/kg at weeks 0, 2, & 6 ☐ **Maintenance Dose:** Infuse 5mg/kg every 8 weeks		
Rinvoq	☐ 15mg	☐ Take 1 tablet PO daily		
☐ Rituxan ☐ Truxima	☐ 100mg Vial ☐ 500mg Vial	☐ Infuse 1000mg on day 1 and day 15		

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

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☐ Therapy Continuation | Stop Date: _____ ☐ Weeks Completed: ☐0 ☐ 2 ☐ 4 ☐ 6
Allergies: _____
TB Results & Date (Please provide copy of result): _____
☐ Bone Density Score & Date (Please provide a copy of results): _____

Medication	Dose Strength	Directions	Qty	Refills
Simponi/Simponi Aria	**Simponi:** ☐ SmartJect 50mg/0.5mL ☐ 50mg/0.5mL PFS **Simponi Aria:** ☐ 50mg/4mL Vial	**Simponi:** ☐ Inject 50mg SC once per month **Simponi Aria:** ☐ Infuse _____ mg(2mg/kg) IV over 30 minutes at 0 and 4 weeks, then every 8 weeks		
Stelara	☐ 45mg/0.5mL PFS ☐ 90mg/mL PFS	☐ Inject 45mg SC on Day 1 (<100kg) ☐ Inject 90mg SC on day 1 (>100kg) ☐ Inject 45mg SC on Day 29 and every 12 weeks thereafter (<100kg) ☐ Inject 90mg SC on Day 29 and every 12 weeks thereafter (>100kg)		
Skyrizi	☐ 150 mg/mL in each single-dose prefilled pen ☐ 90 mg/mL in each single-dose prefilled syringe ☐ 150 mg/mL in each single-dose prefilled syringe	☐ **Initial Dose:** Inject 150mg SC weeks 0, and 4 ☐ **Maintenance Dose:** Inject 150mg SC every 12 weeks		
Taltz	☐ 80mg/mL AutoInjector	☐ **Starter Dose:** Inject 160mg SC on Day 1 ☐ **Maintenance:** Inject 80mg SC every 4 weeks		
Tremfya	☐100mg PFS ☐100mg One-Press autoinjector	☐ Inject SubQ 100 mg at weeks 0, 4, and then every 8 weeks thereafter.		
Tymlos	☐ 80mcg/0.04mL	☐ Inject 80mcg SC once daily into periumbilical region; give with supplemental calcium and vitamin D if dietary intake is not adequate	☐ 1-Prefilled Pen	
Xeljanz/XR	**Xeljanz:** ☐ 5mg Tablet **Xeljanz XR:** ☐ 11mg Tablet	**Xeljanz:** ☐ Take one tablet twice daily **Xeljanz XR:** ☐ Take one tablet once daily	☐ 60 ☐ 30	

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