| Rheumatology Referral Form | SUPERIOR BIOLOGICS<br>Fax Referral To: 914-747-1170<br>Phone: 855-747-1150 | 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<br>☐ Auto Injector 162mg/0.9mL | ☐ <100kg Inject 162mg/0.9mL SUBQ every 2 weeks<br>☐ >100kg Inject 162mg/0.9mL SUBQ every week | | |
| Benlysta | ☐ 10mg/kg<br>☐ 200mg PFS<br>☐ 200mg Autoinjector | ☐ **IV Starter Dose:** Infuse 10mg/kg every 2 weeks for 3 doses<br>☐ **IV Maintenance:** Inject 10mg/kg every 4 weeks<br>☐ Inject 200mg SUBQ once weekly (if switching from IV administer first SUBQ dose 1-4 weeks after last IV dose) | | |
| Cimzia | ☐ Starter Kit ☐ Syringe ☐ Vial | ☐ **Starter Dose:** Inject 400mg SUBQ on week 0, 2, and 4<br>☐ **Maintenance Dose:** Inject 200mg SUBQ every 2 weeks<br>☐ **Maintenance Dose:** Inject 400mg SUBQ once a month | | |
| Cosentyx | ☐ 150mg Sensoready Pen<br>☐ 300mg Sensoready Pen | ☐ **Starter Dose:** Inject 150mg SUBQ on week 0, 1, 2, 3, and 4<br>☐ **Maintenance:** Inject 150mg SUBQ every 4 weeks<br>☐ **Starter Dose:** Inject 300mg SUBQ on week 0, 1, 2, 3, and 4<br>☐ **Maintenance:** Inject 300mg SUBQ every 4 weeks | ☐ 5<br>☐ 1<br>☐ 10<br>☐ 2 | |
| Enbrel | ☐ 25mg Syringe ☐ 0.25mg Vial<br>☐ 50mg Syringe ☐ 50mg SureClick Pen<br>☐ Mini 50mg/mL | ☐ Inject 50mg SUBQ every week<br>☐ Inject _____mg(0.8mg/kg x_____kg) SC every week | | |
| Evenity | ☐ 105mg/1.17mL | ☐ Inject 2 syringes (105mg each) for total dose of 210mg SUBQ once monthly | ☐ 2 | |
| Forteo | ☐ 600mcg/2.4mL PFS | ☐ **Maintenance:** Inject 20mcg SUBQ once daily | ☐ 1 | |
| ☐ Humira<br>☐ Adalimumab *(biosimilar)* | ☐ 10mg Syringe<br>☐ 20mg Syringe<br>☐ 40mg/0.4mL Syringe<br>☐ 40mg/0.4mL Pen | ☐ Inject 10mg SUBQ every other week (10 to <15kg)<br>☐ Inject 20mg SUBQ every other week (15 to <30kg)<br>☐ Inject 40mg SUBQ every other week (30kg)<br>☐ Inject 40mg SUBQ once weekly | | |

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

**Rheumatology Referral Form**

Date: _____

**SUPERIOR BIOLOGICS**
**Fax Referral To: 914-747-1170**
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SUPERIOR BIOLOGICS

## Patient Information

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
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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 |
|---|---|---|---|---|
| Kevzara | ☐ 150mg/1.14mL PFS ☐ 200mg/1.14mL Pen | ☐ Inject 200mg SUBQ once every 2 weeks<br>☐ 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<br>☐ 125mg Pen Syringe | ☐ **IV Dosage:** Infuse_____ mg at weeks 0, 2, 4 then every 4 weeks thereafter<br>☐ **SUBQ Dosage:** Inject 125mg SUBQ once a week | | |
| Otezla | ☐ Starter Pack ☐ 30mg Tablet | ☐ **Starter Pack:** Use as directed<br>☐ **Maintenance Dose:** Take one tablet PO BID | | |
| Prolia | ☐ 60mg PFS | ☐ Inject 1 syringe SUBQ every 6 months | | |
| ☐ Avsola<br>☐ Inflectra<br>☐ Remicade<br>☐ Renflexis | ☐ 100mg Vial | ☐ **Loading Dose:** Infuse 5mg/kg at weeks 0, 2, & 6<br>☐ **Maintenance Dose:** Infuse 5mg/kg every 8 weeks | | |
| Rinvoq | ☐ 15mg | ☐ Take 1 tablet PO daily | | |
| ☐ Rituxan<br>☐ 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:**<br>☐ SmartJect 50mg/0.5mL<br>☐ 50mg/0.5mL PFS<br>**Simponi Aria:**<br>☐ 50mg/4mL Vial | **Simponi:**<br>☐ Inject 50mg SUBQ once per month<br>**Simponi Aria:**<br>☐ Infuse _____ mg(2mg/kg) IV over 30 minutes at 0 and 4 weeks, then every 8 weeks | | |
| Stelara | ☐ 45mg/0.5mL PFS<br>☐ 90mg/mL PFS | ☐ Inject 45mg SUBQ on Day 1 (<100kg)<br>☐ Inject 90mg SUBQ on day 1 (>100kg)<br>☐ Inject 45mg SUBQ on Day 29 and every 12 weeks thereafter (<100kg)<br>☐ Inject 90mg SUBQ on Day 29 and every 12 weeks thereafter (>100kg) | | |
| Skyrizi | ☐ 150 mg/mL in each single-dose prefilled pen<br>☐ 90 mg/mL in each single-dose prefilled syringe<br>☐ 150 mg/mL in each single-dose prefilled syringe | ☐ **Initial Dose:** Inject 150mg SUBQ weeks 0, and 4<br>☐ **Maintenance Dose:** Inject 150mg SUBQ every 12 weeks | | |
| Taltz | ☐ 80mg/mL AutoInjector | ☐ **Starter Dose:** Inject 160mg SUBQ on Day 1<br>☐ **Maintenance:** Inject 80mg SUBQ every 4 weeks | | |
| Tremfya | 100mg PFS<br>100mg One-Press autoinjector | ☐ Inject SUBQ 100 mg at weeks 0, 4, and then every 8 weeks thereafter. | | |
| Tymlos | ☐ 80mcg/0.04mL | ☐ Inject 80mcg SUBQ once daily into periumbilical region; give with supplemental calcium and vitamin D if dietary intake is not adequate | ☐ 1-Prefilled Pen | |
| Xeljanz/XR | **Xeljanz:**<br>☐ 5mg Tablet<br>**Xeljanz XR:**<br>☐ 11mg Tablet | **Xeljanz:**<br>☐ Take one tablet twice daily<br>**Xeljanz XR:**<br>☐ Take one tablet once daily | ☐ 60<br>☐ 30 | |

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