Elwyn SPECIALTY CARE
A BIOMATRIX Company
FEB 2018

RA & INFLAMMATION REFERRAL FORM

3070 McCann Farm Drive | Suite 101
Garnet Valley, PA 19060
1-866-317-0672 TEL: 610-545-6040 FAX: 610-545-6030

Today's Date

☐ CURRENT PATIENT
☐ NEW PATIENT

Patient Name ____________________ SS#____________ DOB ____________ ☐ Male ☐ Female
Street Address ____________________ Apt# ______ City ____________ State ______ Zip ______
Daytime Tel ____________ Cell ____________ Email ____________ Height ______ Weight ______ BSA ______
Ship to Patient at ☐ Home ☐ Work OR Patient will pick up at ☐ Physician Office Local Pharmacy Phone____________
Allergies ____________________ Comorbidities ____________________
Current Medications (if necessary, please fax a complete list) ____________________

PRACTICE NAME	PRACTICE ADDRESS	CONTACT INFORMATION	LICENSE INFORMATION

REFERRAL SOURCE INFORMATION

☐ __________ #__________ ☐ __________ #__________ ☐ __________ #__________
☐ __________ #__________ ☐ __________ #__________ ☐ __________ #__________
☐ __________ #__________ ☐ __________ #__________ ☐ __________ #__________
☐ __________ #__________ ☐ __________ #__________ ☐ __________ #__________
☐ __________ #__________ ☐ __________ #__________ ☐ __________ #__________

Insured's Name ____________________ Relation to Patient ____________________
Eligible for Medicare ☐ Yes ☐ No If yes, Medicare# ____________ Prescription Card ☐ Yes ☐ No If Yes, Carrier ____________
Tel ____________ Fax ____________ Policy/Group# ____________
Bin# ____________ Pcn# ____________ RXID# ____________ RX Group# ____________

ICD-10 Diagnosis____________ PPD (TB Test)____________ Chest X-ray ____________
Date of Labs____________ Rheumatoid Factor Positive ________ Total Swollen Joints ________
Previously treated? ☐ Yes ☐ No If yes, what drugs ____________________

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

TALTZ 80mg ☐ Autoinjector ☐ Prefilled Syringe
Psoriatic Arthritis Start Dose: ☐ 160 mg SQ at week 0, followed by 80 mg every 4 weeks
QTY: 2 Refill:_____
Maintenance: ☐ Inject 80mg SQ every 4 weeks QTY______ Refills ______
☐ Other: ____________________ QTY______ Refills ______

KEVZARA® (sarilumab)
Dose: ☐ 200 mg/1.14 mL PFS ☐ 150 mg/1.14 mL PFS
Dispense: ☐ Inject 150 mg subcutaneously every other week QTY: 2 Refills ______
☐ Inject 200 mg subcutaneously every other week QTY: 2 Refills ______

CIMZIA® (certolizumab pegol)
Initial Dose: ☐ 400mg (two 200mg SQ injections) at weeks 0, 2 & 4 (Starter Kit #6)
Maintenance Dose: ☐ 200mg SQ injection every other week
☐ Other ____________________ QTY______ Refills ______

HUMIRA® (adalimumab) Patient wt (kg) ________
Dose ☐ 40mg/0.8mL PFS ☐ 40mg/0.8mL Pens ☐ 20mg/0.4mL PFS
Dispense: ☐ Inject 40mg subcutaneously every other week QTY______ Refills ______
Juvenile Arthritis ☐ Patient weight 15kg to < 30kg inject 20mg SQ every other week
☐ Patient weight > 30kg inject 40mg SQ every other week

REMICADE 100 mg vial ☐ MD Office Infusion ☐ Home Infusion
Infusion Supplies: ☐ YES ☐ NO
☐ **Starting Dose:** ____mg/kg ____mg on week 0, week 2 & week 6 then,
☐ **Maintenance Dose:** ____mg/kg _____ mg every 8 weeks for ____ infusions every 8 weeks
☐ Other ____________________ QTY______ Refills ______

STELARA
Starting Dose: ☐ 45mg ☐ 90mg SQ initially & 4 weeks later QTY: 2
Maintenance Dose: ☐ 45mg ☐ 90mg SQ every 12 weeks QTY______ Refills ______

☐ **ACTEMRA®** (tocilizumab) Vials Patient wt (kg) ________
☐ 80mg/4ml ☐ 200mg/10ml ☐ 400mg/20ml
Sig: ____________________
QTY______ Refills ______

☐ **ACTEMRA®** (tocilizumab) PFS
Inject 162mg (1 syringe) subcutaneously:
☐ every other week (pt wt<100kg)
☐ every week (pt wt >100kg or per clinical response)
QTY______ Refills ______

SIMPONI® (golimumab) inject 50mg subcutaneously once per month
Dose: *SmartJect™* ☐ 50mg/0.5mL | Prefilled Syringe ☐ 50mg/0.5mL

SIMPONI ARIA® ☐ 50mg/4mL vial QTY __________ (vials) Refills __________
Infuse ____mg (2mg/kg) IV over 30 minutes at weeks 0 and 4, then every 8 weeks

FORTEO® ☐ Pen (#1 pen) ☐ Inject 20mcg SQ Daily Refills __________
☐ Pen Needles 31G 3/16" Qty: 1 Box Refills ______

KINERET® (anakinra) ☐ Inject _____ mg SQ every day Qty _____ Refills ______

ORENCIA® ☐ Inject 125mg subcutaneously weekly Qty 28 day Refills ______
☐ 250mg Vial (IV use only) Loading Dose: 10mg/kg IV x 1 dose,
then 125mg SC weekly, start within 24hrs of IV dose, 1 dose, 4 week supply

XELJANZ® (tofacitinib citrate) ☐ 5mg tablet **XELJANZ XR®** (tofacitinib citrate) ☐ 11mg tablet
Sig: Take ☐ 5mg tablet by mouth twice daily **OR** ☐ 11mg tablet by mouth once daily
QTY ______ Refills ______

ENBREL® **Dose:** PFS ☐ 25mg ☐ 50mg | Multiuse Vial ☐ 25mg | SureClick™ ☐ 50mg
Dispense: ☐ 1x week ☐ 2x week QTY______ Refills ______

OTEZLA® ☐ 28 day Titration Starter Pack ☐ Tablets
☐ Take as directed *These directions can only be selected for the Titration Starter Pack*
QTY 55 Refills _____
☐ Take 30 mg once daily QTY 30 Refills _____
☐ Take 30 mg twice daily QTY 60 Refills _____

COSENTYX
Starter Dose ☐ Sensoready® Pen ☐ Prefilled Syringe
SIG: ☐ Inject 150 mg dose SQ once weekly for Weeks 0, 1, 2, 3, and 4
QTY: ______ Refills: ______
Maintenance Supply ☐ Sensoready® Pen ☐ Prefilled Syringe
SIG: ☐ Inject 150 mg dose SQ once every 4 weeks QTY ______ Refills ______

OTHER ____________________
Sig ____________________ QTY ______ Refills ______

By signing this form and utilizing our services, you are authorizing Elwyn Specialty Care and it's employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature (signature required. NO STAMPS)____________________ **Date**____________

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.

Please fax completed referral form to **Elwyn Specialty Care** at **610-545-6030** Visit **WWW.ELWYNSPECIALTYCARE.COM** for online fillable forms.

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NEW REFERRAL CHECKLIST

PLEASE USE THIS CHECKLIST FOR PATIENTS WITH RHEUMATOID ARTHRITIS

Please use the attached checklist as a reference in order to provide the proper documentation to process the required prior authorization for your patient's treatment. All lab reports (or EMR) must contain the following information within the last 30 days.

Please forward any updates to us you receive from the insurance company regarding approvals or denials

REQUIRED INFORMATION:

- ☐ Patient name
- ☐ Patient Demographics (Address, Phone Number, DOB, etc…)
- ☐ Medication list and allergies
- ☐ Insurance information with RX insurance. Please include copy of card.
  If the only card included is a medical card, please include local pharmacy information.
- ☐ MD name/NPI/Office contact/Phone number
- ☐ Drug indicated with refills
- ☐ MD signature and date on referral form
- ☐ Recent TB test results and date
- ☐ Previous treatment
- ☐ Symptoms
- ☐ Clinical notes

Fax the requested documentation to (610) 545-6030

Toll Free: 1-855-ELWYN-RX (359-9679) Direct Phone: (610) 545-6040

ElwynSpecialtyCare.com

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