Faxed or E-scribed Prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy.

Access Specialty Pharmacy

Rheumatology Prescription Referral Form (A-E)

Send your RX to: Access Specialty Pharmacy
Fax: 661-489-3553

If you have any questions or concerns,
Please contact us at 661-489-3500 or toll free (833-647-0821)

Date Medication Needed: _____ Deliver to: ☐ Patient's home ☐ Prescriber's office ☐ Pick-up

Injection training by pharmacy? _____

1: Patient Information

Patient Name: _____ **Birthdate:** _____ **Sex: Male Female** **Height:** _____ **Weight:** _____ **lbs. Kg.**
Soc. Sec #: _____ **Preferred Phone:** _____ **Known Allergies:** _____
Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Alternate Caregiver Name: _____ **Preferred Phone:** _____

Insurance Information: Please Fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)

2. Prescriber Information

Provider Name: _____ **DEA #:** _____ **NPI#:** _____
Address: _____ **Phone:** _____ **Fax:** _____
City, State, ZIP: _____ **Key Contact:** _____ **Phone:** _____

3: Diagnosis/Clinical Information

Please FAX recent clinical notes, labs, Tests, with the prescription

Diagnosis – *Please Include diagnosis name with ICD-10 code*

☐ M06.9 Rheumatoid arthritis, unspecified
☐ M08.00 Unspecified juvenile rheumatoid arthritis of unspecified site
☐ M08.3 Juvenile rheumatoid polyarthritis (seronegative)
☐ M45.9 Ankylosing spondylitis of unspecified sites in spine
☐ L40.59 Other Psoriatic Anthropathy
☐ Other Diagnosis: ICD-10 Code_____ Description: _____
Date of Diagnosis: _____
Has a TB test been performed? ☐ Yes ☐ No
Does the patient have an active infection? ☐ Yes ☐ No
Start Date_____ **Review Date**_____

Additional Information Therapy: ☐ New ☐ Reauthorization ☐ Restart

Weight_____ ☐ Kg ☐ lbs Height_____ ☐ cm ☐ inc
Allergies: _____
Lab Data: _____
Prior Therapies: _____
Concomitant Medications: _____
Additional Comments: _____
Injection Training Required: ☐ Yes ☐ No

4: Prescription Information

Medication	Dose/Strength	Sig	Qty/Refills
☐ **Actemra**	☐ 162mg/0.9ml Prefilled Syringe ☐ 162mg/0.9ml ACTPen Autoinjector	☐ **For patients weighing < 100 kg:** Inject 162mg SQ every other week, followed by an increase to every week based on clinical response ☐ **For patients weighing > 100 kg**: Inject 162mg SQ every week	Qty:_____ Refills:_____
☐ **Benlysta**	☐ 200mg/ml Prefilled Syringe ☐ 200mg/ml Autoinjector	☐ **Maintenance Dose:** Inject 200 mg SQ once every week	Qty:_____ Refills:_____
☐ **Cimzia**	☐ 200mg/ml Starter Kit (6 prefilled syringes)	☐ **Induction Dose:** Inject 400mg SQ at weeks 0, 2 and 4	Qty:_____ Refills:_____
☐ **Cimzia**	☐ 200mg/ml Vial Kit	☐ **Maintenance Dose:** Inject 200mg SQ every OTHER week ☐ **Maintenance Dose**: Inject 400 mg SQ every four weeks ☐ **Other:** _____	Qty:_____ Refills:_____
☐ **Cosentyx**	☐ Sensoready pen 150 mg/ml Injection ☐ Prefilled Syringe 150mg/ml Injection	Psoriatic Arthritis with Coexisting Moderate to Severe Plaque Psoriasis ☐ **Loading Dose**: Inject 300 mg (2 injections) SQ at weeks 0, 1, 2, 3, and 4 (0 refills) ☐ **Maintenance Dose**: Inject 300 mg (2 injections) SQ every 4 weeks Other Psoriatic Arthritis or Ankylosing Spondylitis ☐ **With Loading Dose:** Inject 150mg (1 injection) SQ at weeks 0, 1, 2, 3 and 4, and then every 4 weeks thereafter (0 refills) ☐ **Without Loading Dose:** Inject 150 mg (one injection) SQ every 4 weeks ☐ **Other:** _____	Qty:_____ Refills:_____
☐ **Enbrel**	☐ 25mg/0.5ml Prefilled Syringes ☐ 25mg Vial ☐ 50mg/ml Sureclick Autoinjector ☐ 50mg/ml Prefilled Syringe ☐ 50mg/ml Enbrel Mini Prefilled Catridge for use with the AutoTouch reusable autoinjector only	☐ Inject 25 mg SQ twice a week (72 – 96 hours apart) ☐ Inject 50mg SQ once a week ☐ **Other:** _____	Qty:_____ Refills:_____

Patient Support Programs: Please sign and date below to enroll in the pharmaceutical company assisted patient support program (if applicable)

Patient Signature: _____ **Date:** _____

*Prescriber Authorization: I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.
☐ Product Substitution permitted ☐ Dispense as written
Prescriber's Signature: _____ **Date:** _____

I authorize Access Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process