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 (H-O)

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

If you have any questions or concerns,
Please contact us at 661-647-3500 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

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
☐ **Humira**	☐ 10mg/0.1ml Prefilled Syringes (citrate-free) ☐ 20mg/0.2ml Prefilled Syringes (citrate-free) ☐ 40mg/0.4ml Prefilled Syringes (citrate-free) ☐ 40mg/0.4ml Pen (citrate-free) ☐ 10mg/0.2ml Prefilled Syringe ☐ 20mg/0.4ml Prefilled Syringe ☐ 40mg/0.8ml Prefilled Syringe ☐ 40mg/0.8ml Pen	☐ Inject 40mg SQ every OTHER week ☐ Other: _____	Qty: _____ Refills: _____
☐ **Kevzara**	☐ 200mg/1.14ml Prefilled Syringe ☐ 150mg/1.14ml Prefilled Syringe ☐ 200mg/1.14ml Prefilled Pen auto-injector ☐ 150mg/1.14ml Prefilled Pen auto-injector	☐ Inject 200mg SQ once every two weeks ☐ Inject 150mg SQ once every two weeks	Qty:_____ Refills:_____
☐ **Olumiant**	☐ 1mg Tablet ☐ 2mg Tablet	☐ Take 2 mg by mouth once daily ☐ Other:_____	Qty:_____ Refills:_____
☐ **Orencia**	☐ ClickJect Autoinjector 125mg/ml pack of 4 ☐ 125mg/ml Prefilled Syringe ☐ 87.5mg/0.7ml Prefilled Syringe ☐ 50mg/0.4ml Prefilled Syringe	☐ Inject 125mg SQ every week ☐ Inject 87.5mg SQ every week ☐ Inject 50mg SQ every week ☐ Other: _____	Qty:_____ Refills:_____
☐ **Otezla**	☐ Titration Starter Pack	☐ **Day 1**: 10mg by mouth once daily in the morning ☐ **Day 2:** 10mg by mouth in the morning and 10mg by mouth in the evening ☐ **Day 3:** 10mg by mouth in the morning and 20mg by mouth in the evening ☐ **Day 4**: 20mg by mouth in the morning and 20mg by mouth in the evening ☐ **Day 5:** 20mg by mouth in the morning and 30mg by mouth in the evening ☐ **Day 6 and thereafter**: 30mg by mouth twice daily	Qty:_____ Refills:_____
☐ **Otezla**	☐ 30mg Tablet	☐ **Maintenance Dose**: 30mg by mouth twice daily ☐ 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