Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to pharmacy.

Rheumatology (A-K)

Referral for Medication and Patient Management Program

OptiMed

Phone: 877.385.0535
Fax: 877.326.2856

Please fax a copy (front and back) of all the patient's pharmacy and medical insurance cards as well as any relevant clinical notes/documents

Patient Demographics

Name _____ Sex ☐M ☐F
DOB _____ SSN _____
Phone _____ 2nd Phone _____
Address _____ Apt/Suite _____
City, State, ZIP _____
Primary language, if other than English _____

Provider Information

Prescriber _____
NPI _____ DEA _____
Practice Name _____
Address _____
City, State, ZIP _____
Phone _____ Fax _____ Key contact _____

This is a ☐ New Rx ☐ Refill

Training by ☐ Prescriber's office ☐ Pharmacy to facilitate ☐ Not needed

Ship first fill to ☐ Prescriber's office ☐ Patient ☐ Other _____

Clinical Information

Diagnosis
☐ L40.50 Arthropathic psoriasis, unspecified
☐ L40.53 Psoriatic spondylitis
☐ L40.54 Psoriatic juvenile arthropathy
☐ L40.59 Other psoriatic arthropathy
☐ M06.9 Rheumatoid arthritis, unspecified
☐ M08.00 Unspecified juvenile rheumatoid arthritis of unspecified site
☐ M45.9 Ankylosing spondylitis of unspecified sites in spine
☐ Other (include ICD-10) _____

Date of diagnosis _____

Prior failed treatments & reason for discontinuation
_____
_____
_____

Concomitant medications
_____
_____
_____

Date of negative TB test _____
or ☐ TB test pending, will fax results
HBV negative or treated ☐ Yes ☐ No
Weight _____ ☐ lb ☐ kg
Height _____ ☐ in
Allergies _____
_____
Other notes _____

Medication	Directions	Quantity	Refills
☐ **Actemra®** 162mg ^ (tocilizumab)	☐ Weight < 100kg or dose modification*: Inject 162mg SQ every OTHER week. ☐ Weight ≥ 100kg or insufficient response: Inject 162mg SQ every week. ^**REQUIRED:** ANC_____ Plt_____ ALT_____ AST_____ Date_____	2 pens/syringes 4 pens/syringes	_____
☐ **Cimzia®** 200mg (certolizumab pegol)	**Initial:** ☐ Inject 400mg SQ week 0, week 2, and week 4. **Maintenance:** ☐ Beginning week 6, inject 200mg SQ every OTHER week. ☐ Beginning week 8, inject 400mg SQ every 4 weeks.	6 syringes 2 syringes 2 syringes	Zero _____
☐ **Cosentyx®** 150mg (secukinumab)	**Initial:** ☐ Inject 150mg SQ at weeks 0, 1, 2, and 3. ☐ Inject 300mg SQ at weeks 0, 1, 2, and 3. **Maintenance:** ☐ Beginning week 4, inject 150mg SQ once every 4 weeks. ☐ Beginning week 4, inject 300mg SQ once every 4 weeks. ☐ Other: _____	4 pens/syringes 8 pens/syringes 1 pen/syringe 2 pens/syringes ☐ Other _____	Zero Zero _____ _____
☐ **Enbrel®** 50mg ☐ **Enbrel®** 25mg (etanercept)	☐ Inject 50mg SQ once weekly. ☐ Other _____	☐ 4 pens/syringes ☐ 4 Enbrel Mini cartridges* ☐ Other _____	 _____
☐ **Humira®** 40mg ^ (adalimumab)	☐ Inject 40mg SQ every OTHER week. ☐ Inject 40mg SQ once weekly. ☐ Other _____	☐ 2 pens/syringes ☐ 4 pens/syringes ☐ Other _____	 _____
☐ **Kevzara®** 200mg ^ ☐ **Kevzara®** 150mg ^ (sarilumab)	☐ Inject 200mg SQ every OTHER week. ☐ *Dose modification: Inject 150mg SQ every OTHER week. ^**REQUIRED:** ANC_____ Plt_____ ALT_____ AST_____ Date_____	2 syringes 2 syringes	 _____
☐ Other Medication Drug _____	☐ _____	☐ _____	_____

*Reduce dose for management of certain dose-related laboratory changes including neutropenia, thrombocytopenia and elevated liver enzymes.
^**REQUIRED:** Notate or attach a copy of patient's current CBC and CMP. These labs and lipids should be reassessed 4-8 weeks after start of therapy and then at recommended intervals.

For **Actemra® IV infusion** please locate the drug specific referral form at https://www.optimedhealthpartners.com/referrals

*AutoTouch device must be provided to the patient by the referring provider. (Contact your Enbrel representative to request the AutoTouch device.)

^Citrate-free (CF) Humira will be dispensed unless unavailable or otherwise specified.

To order **INFLIXIMAB** IV infusion products such as **Remicade®**, **Inflectra®**, or **Renflexis®**, please locate the **INFLIXIMAB Infusion** referral form at https://www.optimedhealthpartners.com/referrals

*Reduce dose for management of neutropenia, thrombocytopenia and elevated liver enzymes.
^**REQUIRED:** Notate or attach a copy of patient's current CBC and CMP with LFTs. These labs and lipids should be reassessed 4-8 weeks after the start of therapy and then at the recommended intervals.

Please note: To increase adherence and patient acceptance all medications will be dispensed as pen type injectors unless unavailable or otherwise specified.

Provider Signature _____ **Date** _____

My signature for this prescription confirms that the treatment(s) indicated on this referral is/are medically necessary. I authorize OptiMed and its representatives to act as an agent of mine to initiate and execute the patient's insurance prior authorization process and to provide administrative nursing services and supplies if necessary, in conjunction with the therapy prescribed above.

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CLEAR FORM