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

Rheumatology (L-Z)

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
☐ **Olumiant®** 2mg ^ (baricitinib)	☐ Take one tablet (2 mg) PO once daily. ^**REQUIRED:** ANC_____ ALC_____ Hgb_____ GFR_____ ALT_____ AST_____ Date(s) _____	30 tablets	_____
☐ **Orencia®** 125mg (abatacept)	☐ Inject 125mg SQ once weekly.	4 pens/syringes	_____
☐ **Otezla®** 30mg (apremilast)	☐ **Titration Starter Pack:** Take as directed per package. -or- if 14-day starter pack **already given to patient, check here** ☐ Date provided _____ **Maintenance:** ☐ Take one tablet (30mg) PO twice daily. ☐ Take one tablet (30mg) PO once daily (severe renal impairment).	28-day starter pack N/A ☐ 60 tablets ☐ 30 tablets	Zero N/A _____
☐ **Rinvoq™** 15mg XR ^ (upadacitinib)	☐ Take one tablet (15 mg) PO once daily. Do not split, crush, or chew. ^**REQUIRED:** ANC_____ ALC_____ Hgb_____ GFR_____ ALT_____ AST_____ Date(s) _____	30 tablets	_____
☐ **Simponi®** 50mg (golimumab)	☐ Inject 50mg SQ once monthly. ☐ Other _____	1 pen/syringe ☐ Other _____	 _____
☐ **Stelara®** (ustekinumab)	**Select dose:** ☐ Recommended initial dose: 45mg ☐ Recommended dose for weight > 100kg with moderate to severe PsA: 90mg ☐ **Initial:** Inject 1 dose SQ on day 0. ☐ **Maintenance:** Beginning on day 28, inject 1 dose SQ every 12 weeks	 ☐ 1 dose ☐ 1 dose	 Zero _____
☐ **Taltz®** 80mg ^^ (ixekizumab)	☐ **Initial:** Inject 160mg (2 injections) SQ at week 0. ☐ **Maintenance:** Beginning week 4, inject 80mg (1 injection) SQ once every 4 weeks.	2 pens/syringes 1 pen/syringe	Zero _____
☐ **Xeljanz®** 5mg ^ ☐ **Xeljanz XR®** 11mg ^ (tofacitinib)	☐ Take one tablet (5mg) PO twice daily. ☐ *Dose adjustment: Take one tablet (5mg) PO ONCE daily. ☐ Take one tablet (11mg) PO once daily. Do not crush, split, or chew.	^**REQUIRED:** ANC_____ Lymph_____ Hgb_____ Date_____ ☐ 60 tablets ☐ 30 tablets ☐ 30 tablets	 _____ _____

^^For psoriatic arthritis (PsA) patients with coexistent moderate-to-severe plaque psoriasis, use the dosing regimen for plaque psoriasis (found on OptiMed's Dermatology N-Z referral form).

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

To order **RITUXAN® / RITUXIMAB** IV infusion, please locate the **RITUXIMAB Infusion** referral form at https://www.optimedhealthpartners.com/referrals

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

Administration: OptiMed Infusion Center or Home Infusion Services nurse to administer Stelara SQ. Alternatively, the patient may be trained to self-administer as appropriate.

*For patients with mod-to-severe renal impairment, moderate hepatic impairment, or strong CYP450 drug interactions, use half the total daily dose. Not recommended with severe hepatic impairment.

^**REQUIRED:** Notate or attach a copy of patient's current CBC and CMP with LFTs. These labs and lipids should be assessed at baseline and reassessed 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