Rheumatoid Arthritis Prescription Referral Form Bushnell: Phone: 1.352.793.8000 Fax: 1.352.793.8007 Wildwood:Phone: 1.352.748.9900 Fax: 1.352.748.9902



www.safescriptpharmacy.com



1. Patient Information								
Patient Name:			SSN:			DOB:		
A	ddress:		City:		State:	Zip:		
Н	ome Phone:	Cell Phone:		Email Address	:			
Se	ex: □Male □Female	Height:	Weight: 🗌 lbs. 🗆 kg.	Known Alle	ergies:			
2. Insurance Information:								
Please fax front and back copy of all Insurance cards (Prescription and Medical)								
3. Diagnosis/Clinical Information:								
Pl	Please fax recent clinical notes, labs, and tests with the prescription to expedite the Prior Authorization							
D	iagnosis:			ICD 10:				
4. Prescription Information: For IV medications attach a copy of your prescription								
	Medication	Dose/Strength	Sig/Directions			Qty	Refills	
	Benlysta*	□ 200mg/ml autoinjector	□ Inject 200mg SC once weekly i	n the abdomen or t	thigh	4-week supply	iterino	
		200mg/ml PFS *If transitioning from IV therapy with Benlysta to SC administration,						
			administer the first SC dose 1 to 4	weeks after the las	st IV dose			
	□ Enbrel* □ 50mg/ml SureClick [™] Autoinjector □ Inject 50mg SC ONCE a week					4-week supply		
	□ 50mg/ml Prefilled Syringe □ Inject 25mg TWICE a week, 72 to 96 hours apart							
25mg/0.5ml Prefilled Syringe Other						4-week supply		
	Forteo [*]	□ 600mcg/2.4ml PFS	☐ Inject 20mcg SC, as directed, c ☐ Other	□ Inject 20mcg SC, as directed, once daily				
	U Humira*		□ Inject 40mg SC every OTHER week			4-week supply		
			□ Inject 40mg SC ONCE a week					
	□ Humira* □ 40mg/0.4ml Citrate-Free		□ Inject 40mg SC every OTHER week			4-week supply		
	Citiate-rree							
	□ Kevzara* □ 150mg/1.14ml PFS		□ Inject 200mg SC once every 2 weeks			4-week supply		
		□ 200mg/1.14ml PFS						
	Otezla* Pen Needles	orm available at avella.com/forms			28 needles			
	❑ Pen Needles □ 31gauge 6mm □ Rinvoq* □ 15mg Tablet □ Take one tablet by mouth dail		y		30 day supply			
				· · · ·				
	□ Simponi [*]	50mg/0.5ml Prefilled Syringe			4-week supply			
	□ Other	□ 50mg/0.5ml Autoinjector □ Other □						
	Ship to: 🗌 Patient 🔲 Office 🔲 Other							
5	5. Physician Information:							
Pi	rescriber Name:		Prescriber NPI: DE		A#:			
Address:			City:	State:		Zip:		
	rimary Office Contact:		Fax Number: Phone Numb			er:		
0	Office Contact Email:							
	Prescriber Signature: Prescriber, please sign and date below *I authorize Rosemont Specialty Pharmacy and it's representatives to act as my authorized agent to secure coverage and initiate prior authorization process for my patient(s), and to sign any necessary forms on my behalf as authorized							
a	agents, including the recipt of any required prior 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 fullfill this prescription, I further authorize to forward this information and any related to coverage of the product to another pharmacy of patient's choice or in the patient's insurer's provider network.							
	□ Dispense as written □ Substitution Permissible							
Prescriber's Signature Date								
Confidentiality Statement: This message is intended only for the individual or entity to which it is addressed. It may contain information which may be proprietary and confidential. It may also contain privileged, confidential information which is exempt from disclosure under applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA). If you are not the intended recipient, please note that, you are strictly prohibited from discemination which may be proprietary and confidential. It may also contain privileged, confidential information which may be proprietary and confidential. It may also contain privileged, confidential information which may be proprietary and confidential. It may also contain privileged, confidential formation which may be proprietary and confidential. It may also contain privileged, confidential information which may be proprietary and confidential. It may also contain privileged, confidential is different on the interval of the transmitted material. There you, the sentence of the transmitted material. There you received this communication in error, please notify the senter immediately at the address and the address and the interval of the transmitted material. Thank you.								
	from disseminating or	empt from disclosure under applicable laws, including the H distributing this information (other than to the intended re telephone number set forth herei	carri insurance Portability and Accountability Act (HIPAA), cipient) or copying this information. If you received this co n and obtain instructions as to proper destruction of the t	myou are not the intended re ommunication in error, please ransmitted material. Thank yo	notify the sender immed	you are strictly prohibited iately at the address and		
_		This prescription is vali	d only if transmitted by facsimile machine	by a licensed prescribe	er.			
R	RSP919							