

RHEUMATOLOGY REFERRAL FORM

Non-Infusion Drug Names Starting with A – H Prescriber, please sign and fax completed form to 713.704.3841 For questions, please call 281.698.6100

SHIP	□ Patient
TO:	☐ Office (1st dose)
	☐ Office (All doses)

Patient Information	**Pleas	se include copy	of prescription	and medica	al insuraı	псе са	rd, fron	t and l	oack**				
Patient Name:				Da	ate of Bi	rth:							
Street Address:	Phone:			hone:									
City, State, Zip:	Allergie			llergies:									
Prescriber Information													
Prescriber Name:				N	IPI:								
Specialty:					hone:								
Office Street Address:				 Fa	ax:								
City, State, Zip:				Of	Office Cor	tact:							
Patient Medical Informat	ion **	Please include	e copies of any	pertinent clin	nical not	es and	lab wo	rk **					
Diagnosis (ICD-10):	☐ M06.9 (Rheur ☐ M08.0 (Juveni		•	0.59 (Psoriat 0.54 (Psoriat		,	hritis)				osing Spondyli		
Diagnosis Date:	Date of negati	ve TB Test:	Da	te of negative	e chest	K-ray (i	f TB po	sitive)	:				
Previous and/or Current	Medications Used to	Treat this Dia	gnosis:										
Medication Name(s)		Current Use	Start Date	End Date	_		Reasor	_					
							Other E						
			+				Other E						
Ducassintian Information							Other E	xpiana	ition:	Fa.:::::		Defille	
Prescription Information					Ų	uantity	/			Form		Refills	
☐ Actemra (tocilizumab)	☐ Inject 162 mg s ☐ Inject 162 mg s	,	•						0.9 mL 0.9 mL		o Injector	Refills:	
☐ Amjevita	Adult Inject 40 mg subcutaneously every 2 weeks Inject 40 mg subcutaneously weekly Inject 80 mg subcutaneously every 2 weeks to) Pediatric Inject 20 mg subcutaneously every 2 weeks Inject 40 mg subcutaneously every 2 weeks						0 mg/ 0 mg/			□ Auto	o Injector	Pofillo	
(adalimumab-atto)						☐ #2 (20 mg / 0.4 mL) ☐ #2 (40 mg / 0.8 mL) ☐ PFS ☐ Auto Injector (40 mg only) ☐ PFS			Refills:				
☐ Cimzia	Initial (if applicable) ☐ Inject 400 mg subcutaneously at weeks 0, 2, and 4					#6 (2	00 mg	/ mL)		PFS		No Refills	
(certolizumab)	Maintenance (Starting [] weeks after initial dose, if applicable) ☐ Inject 200 mg subcutaneously every 2 weeks ☐ Inject 400 mg subcutaneously every 4 weeks					#2 (2	00 mg	/ mL)		PFS		Refills:	
□ Cosentyx	Initial (if applicable) ☐ Inject 150 mg subcutaneously at weeks 0, 1, 2, 3 ☐ Inject 300 mg subcutaneously at weeks 0, 1, 2, 3						.50 mg .50 mg			□ Auto	o Injector	No Refills	
(secukinumab)	Maintenance (Starting on week 4 after initial dose, if applicable) ☐ Inject 150 mg subcutaneously every 4 weeks ☐ Inject 300 mg subcutaneously every 4 weeks						.50 mg .50 mg			☐ Auto	o Injector	Refills:	
☐ Enbrel (etanercept)	□ Inject 50 mg subcutaneously weekly □ Inject 25 mg subcutaneously two times per week □ Inject 50 mg subcutaneously two times per week □ Inject mg (0.8 mg / kg x weight in kg) subQ weekly						0 mg / _ (25 m	,	L)			Refills:	
□ Humiro	Adult ☐ Inject 40 mg subcutaneously every 2 weeks ☐ Inject 40 mg subcutaneously weekly					,	0 mg/ 0 mg/		,	□ Pen		Refills:	
☐ Humira (adalimumab)	Pediatric ☐ Inject 10 mg subcutaneously every 2 weeks ☐ Inject 20 mg subcutaneously every 2 weeks ☐ Inject 40 mg subcutaneously every 2 weeks					#2 (2	.0 mg/ :0 mg/	0.2 n	nL)		(40 mg only) (all doses)	Refills:	

face of the referral form in your own handwriting.

Prescriber's Signature : _______ Date: ________



RHEUMATOLOGY REFERRAL FORM

Non-Infusion Drug Names Starting with K – S Prescriber, please sign and fax completed form to 713.704.3841 For questions, please call 281.698.6100

SHIP	□ Patient
TO:	☐ Office (1st dose)
	☐ Office (All doses

Patient Information	**Pleas	se include copy	of prescription	and medical	insu	rance card, front and back**			
Patient Name:					of Birth:				
Street Address:	Phone:								
City, State, Zip:	Allergie			es:					
Prescriber Information									
Prescriber Name:				NP	1:				
Specialty:					one:				
Office Street Address:				 Fa>	(:				
City, State, Zip:				Off	ice (Contact:			
Patient Medical Information	tion	**Please inclu	ide copies of a	ny pertinent c	linic	al notes and lab work **			
Diagnosis (ICD-10):	 ☐ M06.9 (Rheur ☐ M08.0 (Juveni 			0.59 (Psoriati 0.54 (Psoriati			9 (Ankylosing Spondylit	tis)	
Diagnosis Date:	Date of negati	ve TB Test:	Da	te of negative	che	st X-ray (if TB positive):			
Previous and/or Current	Medications Used to	Treat this Diag	gnosis:						
Medication Name(s)		Current Use	Start Date	End Date	Dis	continue Reason (if stopped)			
						Failed Other Explanation:			
						ailed Other Explanation:			
						ailed Other Explanation:			
Prescription Information						Quantity	Form	Refills	
☐ Kevzara (sarilumab)	□ Inject 150 mg s □ Inject 200 mg s	•	•			□ #2 (150 mg / 1.14 mL) □ #2 (200 mg / 1.14 mL)	☐ Auto Injector ☐ PFS	Refills:	
☐ Methotrexate	☐ Take tablets by mouth times weekly ☐ Inject mg subcutaneously weekly					□ # (mg tablet) □ #4 (mg / mL)	☐ Tablet ☐ Otrexup Injector ☐ Rasuvo Injector ☐ RediTrex Injector	Refills:	
☐ Olumiant (baricitinib)	☐ Take 1 tablet by mouth daily					☐ #30 (2 mg tablet)	Tablet	Refills:	
☐ Orencia (abatacept)	☐ Inject 125 mg subcutaneously weekly					□ #4 (125 mg / mL)	☐ Auto Injector ☐ PFS	Refills:	
☐ Otezla	Initial (if applicable) ☐ Take as directed on the package instructions					☐ #55 (28-day starter)	Tablet	No Refills	
(apremilast)	Maintenance ☐ Take 1 tablet by mouth twice daily					□ #60 (30 mg tablet)	Tablet	Refills:	
☐ Prednisone	☐ Take tablets by mouth times daily					☐ # (mg tablet)	Tablet	Refills:	
☐ Rinvoq (baricitinib)	☐ Take 1 tablet by mouth daily				☐ #30 (15 mg tablet)	Tablet	Refills:		
☐ Simponi (golimumab)	☐ Inject 50 mg subcutaneously once a month					□ #1 (50 mg / 0.5 mL)	☐ Auto Injector ☐ PFS	Refills:	
☐ Skyrizi	Initial (if applicable) ☐ Inject 150 mg subcutaneously once					□ #1 (150 mg / mL)	☐ Auto Injector ☐ PFS	No Refills	
(risankizumab)	Maintenance (Starting 4 weeks after initial dose, if applicable) □ Inject 150 mg subcutaneously every 12 weeks					□ #1 (150 mg / mL)	☐ Auto Injector ☐ PFS	Refills:	
☐ Stelara	Initial (if applicable) ☐ Inject 45 mg subcutaneously once ☐ Inject 90 mg subcutaneously once					□ #1 (45 mg / 0.5 mL) □ #1 (90 mg / mL)	□ PFS	No Refills	
(ustekinumab)	inumab) Maintenance (Starting 4 weeks after initial dose, if applicable) □ Inject 45 mg subcutaneously every 12 weeks □ Inject 90 mg subcutaneously every 12 weeks					□ #1 (45 mg / 0.5 mL) □ #1 (90 mg / mL)	□ PFS	Refills:	
(doto:unumus)	☐ Inject 45 mg subcutaneously every 12 weeks						□ PFS	Refills:	

Prescriber Signature (No Stamps Permitted)

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RHEUMATOLOGY REFERRAL FORM

Non-Infusion Drug Names Starting with T - Z Prescriber, please sign and fax completed form to 713.704.3841 For questions, please call 281.698.6100

SHIP	□ Patient
TO:	☐ Office (1st dose)
	☐ Office (All doses

Patient information	" " Flea:	se include copy	or prescription	i anu meuicai	insurance caru, iront a	iiu back " "			
Patient Name: Street Address: City, State, Zip:	Phone			te of Birth: one: ergies:					
Prescriber Information									
Prescriber Name: Specialty: Office Street Address: City, State, Zip: Patient Medical Informa Diagnosis (ICD-10):				one: cice Contact: cal notes and lab work c Arthritis)	c Contact: I notes and lab work ** Arthritis) M45.9 (Ankylosing Spondylitis)				
Diagnosis Date:SSS		gative TB Test:			tive chest X-ray (if TB p				
Previous and/or Current Medication Name(s)	Medications Used to	Current Use	start Date	End Date	Discontinue Reason (ii Failed Other Expl Gailed Other Expl Gailed Other Expl	anation:			
Prescription Information	1				Quantity	anation	Form	Refills	
□ Taltz	Initial (if applicable ☐ Inject 160 mg (2	2 x 80 mg) subc			□ #2 (80 mg / ml	_)	☐ Auto Injector ☐ PFS ☐ Auto Injector	No Refills	
(ixekizumab) <u>Maintenance (St</u> □ Inject 80 mg				, if applicable	¹ □ #1 (80 mg / ml	□ #1 (80 mg / mL)		Refills:	
☐ Tremfya		Initial (if applicable) ☐ Inject 100 mg subcutaneously once				nL)	☐ Auto Injector ☐ PFS	No Refills	
(guselkumab)	Maintenance (Starting 4 weeks after initial dose, if applicable) □ Inject 100 mg subcutaneously every 8 weeks				D #1 (100 mg / n	□ #1 (100 mg / mL)		Refills:	
☐ Xeljanz (tofacitinib)	☐ Take 1 tablet by mouth twice daily				□ #60 (5 mg table	☐ #60 (5 mg tablet)		Refills:	
☐ Xeljanz XR (tofacitinib)	☐ Take 1 tablet by mouth daily				☐ #30 (11 mg tab	☐ #30 (11 mg tablet) Tablet		Refills:	
☐ Xeljanz – oral solution (tofacitinib)	☐ Take 3.2 mg by☐ Take 4 mg by m☐ Take 5 mg by m	outh twice dail	у		☐ #1 (1 mg / mL))	240 mL bottle	Refills:	
☐ Other:					#			Refills:	

Prescriber Signature (No Stamps Permitted)	
By signing below, I authorize Memorial Hermann Specialty Pharmacy to serve as my designated agent	t, if needed, to initiate and execute any applicable authoriza-
tion processes with medical and prescription insurance companies. To prohibit generic substitution wr	rite "brand necessary" or "brand medically necessary" on the
face of the referral form in your own handwriting.	
Prescriber's Signature :	Date: