



CEDRA

RHEUMATOLOGY

REFERRAL FORM

FAX: 888.889.7129

TOLL FREE: 844.233.7279

CEDRASPECIALTY.COM

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Preferred Phone: _____
 SSN#: _____ Language: English Other _____
 Address: _____ Sex: Male Female Height: _____ Weight: _____ lbs kg
 City: _____ State: _____ Zip: _____ Known Allergies: _____

*** PLEASE FAX FRONT/BACK COPY OF PHARMACY BENEFIT CARD, MEDICAL INSURANCE CARD, NOTES, LABS & TESTS WITH THE PRESCRIPTION TO EXPEDITE PROCESSING ***

PRESCRIBER INFORMATION

Prescriber Name: _____ DEA#: _____ NPI#: _____ Tax ID#: _____
 Address: _____ Phone: _____ E-mail: _____
 City: _____ State: _____ Zip: _____ Key Contact: _____ Phone: _____ Fax: _____
 STATUS UPDATE PREFERENCE: Phone Text Fax E-mail: _____

DIAGNOSIS/CLINICAL INFORMATION

Rheumatoid Arthritis Ankylosing Spondylitis Juvenile RA (JIA) Psoriatic Arthritis Psoriasis Other: _____ ICD-10 Code: _____
 Severity index: Mild Moderate Severe Has patient been treated previously for this condition? Yes No
 Medication/therapy failed (length of therapy): _____ Therapies: _____
 Is patient currently on therapy? Yes No Type/Medications: _____
 Will patient terminate current therapy upon start of new prescription? Yes No How long should the patient wait before starting the new drug therapy?
 Other medications patient is currently taking including OTC medications with dosage and direction (or fax medication profile): _____
 Which type of TB test has the patient received? PPD QFT-G Results: _____

PRESCRIPTION INFORMATION

MEDICATION	DOSE/STRENGTH	SIG	QTY	REFILLS
ACTEMRA®	162 mg/0.9ml PFS	Inject 162 mg SC ONCE weekly. Inject 162 mg SC every OTHER week. Other		
CIMZIA® Initial Dose	200 mg Starter Kit (6 syringes)	Inject 400 mg SC once, then repeat at weeks 2 and 4.		
CIMZIA® Maintenance Treatment	2 x 200 mg Prefilled Syringe	200 mg SC ONCE every 2 weeks. 400 mg SC ONCE every 4 weeks.		
ENBREL®	50 mg/ml SureClick™ Autoinjector 50 mg/ml Prefilled Syringe 25 mg Prefilled Syringe	Inject 50mg SC ONCE weekly. Inject 25mg TWICE a week, 72 to 96 hours apart. Other		
ENSTILAR®	60 Gram Package	Shake well and apply to _____ ONCE daily for up to 4 weeks. Rub in gently and wash hands after use. Do not use more than 60 grams every 4 days.		
HUMIRA®	40 mg/0.8ml Pen 40 mg/0.8ml Prefilled Syringe	Inject 40 mg SC every OTHER week. Inject 40 mg SC ONCE weekly.		
METHOTREXATE®				
OTEZLA®	Starter RX 30 mg	Starter Pak - Use as directed. TWICE daily.		
ORENCIA®	125 mg/ml Prefilled Syringe (4 syringes) 125 mg/ml Prefilled ClickJect™	Inject 125 mg SC ONCE weekly.		
REMICADE® Wt:	100 mg Vial	Rheumatoid Arthritis: In conjunction with methotrexate, 3 mg/kg at 0, 2 and 6 weeks, then every 8 weeks. Ankylosing Spondylitis 5 mg/kg at 0, 2 and 6 weeks, then every 6 weeks.		
SIMPONI®	50 mg/0.5 ml Prefilled Syringe 50 mg/0.5 ml Autoinjector	Inject 50 mg ONCE a month.		
STELARA®	45 mg/0.5 ml Prefilled Syringe 45 mg/0.5 ml Single Use Vial 90 mg/ml Prefilled Syringe 90 mg/ml Single Use Vial	Psoriasis For patients weighing ≤100 kg (220 lbs), the recommended dose is 45 mg initially and 4 weeks later, followed by 45 mg every 12 weeks. For patients weighting > 100kg (220 lbs) the recommended dose is 90 mg initially and 4 weeks later, followed by 90 mg every 12 weeks. Psoriatic Arthritis The recommended dose is 45 mg initially and 4 weeks later, followed by 45 mg every 12 weeks. For patients with co-existent moderate-to-severe plaque psoriasis weighing >100 kg (220 lbs), the recommended dose is 90 mg initially and 4 weeks later, followed by 90 mg every 12 weeks.		
XELJANZ®	5 mg	5 mg TWICE daily. 5 mg ONCE daily (recommended for patients with moderate and severe renal impairment and moderate hepatic impairment). NOTE: XELJANZ® in patients with severe hepatic impairment is not recommended.		
XELJANZ® XR	11 mg	11 mg ONCE daily. NOTE: XELJANZ® XR in patients with severe hepatic impairment is not recommended.		

Date Medication Needed: _____ Deliver To: Patient Home MD Office

Prescriber Signature: (Please sign and date below)

Your signature authorizes Cedra Pharmacy to act on your behalf to obtain prior authorization for the prescribed medications. We will also pursue available copay and financial assistance on behalf of your patients.

Substitution Permissible _____

Date _____

Dispense as written "DAW" _____

Date _____

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately. 412_RheuRef100-08NY-B

