

Rheumatoid Arthritis Prescription Referral Form



www.pyramidspharmacy.com
 1201 Dairy Ashford Rd., Suite #114
 Houston, Texas, 77079
 Toll Free Phone: (877) 866-9579
 Toll Free Fax: (877) 866-9578

500 Kobayashi Rd ste E
 Webster, TX, 77598
 Toll Free Phone: (855) 339-1931
 Toll Free Fax: (855) 339-1930

All our referral forms available on our website.

Date Medication Needed: _____ Ship To: Patient's Home Prescriber's Office Pick-up (store location): _____ Injection training by pharmacy?

1: Patient Information

Patient Name: _____ Birthdate: _____ Sex: Male Female Height: _____ Weight: _____ lbs. kg.
 Soc. Sec. #: _____ Preferred Phone: _____ Known Allergies: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Alternate Caregiver Name: _____ Preferred Phone: _____

Insurance Information: Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)

2: Prescriber Information

DEA#: _____ NPI#: _____ Tax ID#: _____
 Address: _____ Phone: (_____) _____ - _____ Fax: (_____) _____ - _____
 City: _____ State: _____ Zip: _____ Key Contact: _____ Phone: (_____) _____ - _____

3: Diagnosis/Clinical Information | Please FAX recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization

Diagnosis: _____ Other: _____ BMD/T-score: _____ Date: _____
 Prior failed medications (medication and duration of treatment/reason for d/c): _____ Does patient have a latex allergy? Yes No
 Is Patient at risk for osteoporotic fracture as evident by any of the following?
 History of osteoporotic fracture Site: _____ Date: _____
 Patient has tried and failed an oral bisphosphonate
 Patient has documented contraindication/is intolerant to oral bisphosphonate therapy (please submit a copy of DEXA w/prescription)
 Is patient currently on RA therapy? Yes No
 Medications: _____
 TB/PPD test given? Yes No

4: Prescription Information | Xeljanz NOT to be used in combination with biologic DMARD's

Medication	Dose/Strength	Sig	Qty.	Refills
Actemra®	162mg/0.9ml PFS	Inject 1 syringe SC every week Inject 1 syringe SC every other week	4-week supply	
Cimzia® Initial Dose	200mg Starter Kit (contains 6, 200mg PFS)	Inject 400mg SC once, then repeat at weeks 2 and 4	4-week supply	No refills
Cimzia® Maintenance Treatment	2 x 200mg Prefilled Syringe	200mg SC ONCE every TWO weeks 400mg SC ONCE every FOUR weeks	4-week supply	
Enbrel®	50mg/ml SureClick™ Autoinjector 50mg/ml Prefilled Syringe 25mg/0.5ml Prefilled Syringe	Inject 50mg SC ONCE a week Inject 25mg TWICE a week, 72 to 96 hours apart Other:	4-week supply	
Forteo®	600mcg/2.4ml PFS	Inject 20mcg SC, as directed, once daily	4-week supply	
Pen Needles	31 gauge 6mm		28 needles	
Humira®	40mg/0.8ml Pen 40mg/0.8ml Prefilled Syringe	Inject 40mg SC every OTHER week Inject 40mg SC ONCE a week	4-week supply	
Orencia®	125mg/ml Prefilled Syringe (4 syringes)	Inject 125mg SC ONCE weekly		
Otezla®	Please use Otezla-specific referral form available at pyramidspharmacy.com			
Prolia®	60mg Prefilled Syringe	Inject 60mg SC ONCE every 6 months		
Simponi®	50mg/0.5ml Prefilled Syringe 50mg/0.5ml Autoinjector	Inject 50mg ONCE a month	4-week supply	
Xeljanz®	5mg	Take 5mg by mouth TWICE daily		

Patient Support Programs: Please sign and date below to enroll in the pharmaceutical company assisted patient support program

Patient Signature: _____ Date: _____

Prescriber Signature: Prescriber, please sign and date below

Dispense as written _____ Date _____ Substitution Permissible _____ 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.

of Prescriptions: _____