34-54 Junction Blvd
Jackson Heights, NY 11372
Phone: (718) 565-1009
Fax: (718) 565-1004
www.QEPHEALTH.com

RHEUMATOLOGY REFERRAL FORM

Fax prescription to: (718) 565-1004

Faxed prescriptions can only be accepted from prescribing practitioners

Date Needed By ______________ Ship to: ☐Patient ☐Office ☐Other: ______________

PATIENT INFORMATION

Name ______________________________

Address ______________________________

City ______________ State ______ Zip ________

Phone ______________ SS# ______________ DOB ________

☐Male ☐Female Height__________ Weight __________ Age ______

Allergies ______________________________ ☐NKDA

INSURANCE INFORMATION

Please attach front and back of all insurance and prescription drug cards

PRESCRIBER INFORMATION

Name ______________________________

NPI ______________ State License# ______________

Group/Hospital ______________________________

Address ______________________________

City, State, Zip ______________________________

Main Phone ______________ Fax ______________

Contact Person ______________ Phone ______________

CLINICAL EVALUATION

DIAGNOSIS

- ☐ M06.9 Rheumatoid Arthritis
- ☐ M45.9 Ankylosing Spondylitis
- ☐ M32.10 Systemic Lupus Erythematosus
- ☐ L40.8 Psoriasis Moderate to Severe Plaque
- ☐ L40.50 Psoriatic Arthritis
- ☐ K50.90 Chron's Disease
- ☐ M81.0 Osteoporosis
- ☐ Other ______________ DX code ________

Diagnosis Date ______________________

FORTEO/PROLIA

T-Score __________ Type __________ Date __________

Does patient have latex allergy? ☐Yes ☐No

PREVIOUS MEDICATIONS/THERAPIES

Medication	Duration of treatment/Reason for discontinuation
☐Methotrexate	
☐	
☐	
☐	
☐	

LABS

Has TB test been performed?
☐Yes (please attach results) ☐No

Lab Date: TB Results:

FRACTURE HISTORY

Site	Date

PRESCRIPTION INFORMATION

MEDICATION	DOSAGE & DIRECTIONS	QUANTITY/DURATION	REFILLS
☐ **ACTEMRA (tocilizumab)**	☐ 162mg prefilled syringe - Inject subcutaneously: ☐ ONCE a week ☐ Every OTHER week ☐ __________ vial - Infuse ______ mg at ______________	☐ 4-Weeks supply	
☐ **CIMZIA (certolizumab pegol)** ☐ 200mg x 2 prefilled syringe ☐ 200mg x 2 LYO powder	☐ Starter Kit: Inject 400mg subcutaneously at weeks 0, 2, and 4 ☐ Maintenance: Inject 400mg subcutaneously ONCE a MONTH ☐ Maintenance: Inject 200mg subcutaneously ONCE every 2 weeks	☐ 4-Weeks supply	
☐ **COSENTYX (secukinumab)** ☐ 150mg syringe ☐ 150mg pen	☐ Psoriatic arthritis induction (optional): 150mg subcutaneously at weeks 0, 1, 2, 3, and 4 ☐ Psoriatic arthritis maintenance: 150mg subcutaneously every 4 weeks ☐ Ankylosing spondylitis induction (optional): 150mg subcutaneously at weeks 0, 1, 2, 3, and 4 ☐ Psoriatic arthritis maintenance: 150mg subcutaneously every 4 weeks ☐ Other:	☐ Enter quantity __________	
☐ **ENBREL (etanercept)** ☐ 50mg prefilled syringe ☐ 50mg SureClick	☐ Inject 50mg subcutaneously ONCE a week ☐ Inject 25mg subcutaneously TWICE a week 72-96 hours apart	☐ 4-Weeks supply	
☐ **HUMIRA (adalimumab)** ☐ 40mg/0.8ml pen ☐ 40mg/0.8ml prefilled syringe	☐ Inject 40mg subcutaneously every OTHER week ☐ Inject 40mg subcutaneously ONCE a week	☐ 4-Weeks supply	
☐ **ORENCIA (abatacept)** ☐ 125mg prefilled syringe ☐ 250mg vials	☐ Inject 125mg subcutaneously ONCE a week ☐ Infuse __________ mg at ______________	☐ 4-Weeks supply	
☐ **OTEZLA (apremilast)** ☐ Starter pack ☐ 30mg tablets	☐ Starter pack: Initial titration over 5 days ☐ Maintenance: Take 1 tablet by mouth twice daily	☐ 1 Starter pack ☐ 60 tablets	
☐ **PROLIA (denosumab)**	☐ 60mg syringe: Inject 60mg subcutaneously once every 6 months	☐ 4-Weeks supply	
☐ **REMICADE (infliximab)**	☐ Infuse __________ mg at ______________	☐ 4-Weeks supply	
☐ **RITUXAN (rituximab)**	☐ Infuse __________ mg at ______________	☐ 4-Weeks supply	
☐ **SIMPONI (golimumab)** ☐ 50mg SmartJect ☐ ARIA ☐PFS	☐ Inject 50mg subcutaneously ONCE a MONTH as directed ☐ Infuse __________ mg at weeks 0 and 4, then every 12 weeks	☐ 4-Weeks supply	
☐ **STELARA (ustekinumab)** ☐ 45mg prefilled syringe ☐ 90mg syringe	☐ Inject 45mg on day 0, then week 4, then every 12 weeks ☐ Inject 90mg subcutaneously ONCE a MONTH as directed	☐ 4-Weeks supply	
☐ **XELJANZ (tofacitinib citrate)**	☐ 5mg tablet - Take 1 by mouth TWICE daily	☐ 60 tablets	
☐ **OTHER**			
☐ **OTHER**			

By signing this form and utilizing our services, you are authorizing Queens Express Pharmacy and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature ______________________ ☐DAW Date __________

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