# RHEUMATOLOGY REFERRAL FORM

*Please complete and attach to MDX prior Authorization form*

HAWAII SPECIALTY™ PHARMACY

MDX Hawaii

| PATIENT INFORMATION: | PHYSICIAN INFORMATION: |
|---|---|
| Patient Name: | Physician Name: |
| Address: | Address: |
| City: State: Zip: | City: State: Zip: |
| Home Phone: Alternate Phone: | Phone: Fax: |
| Email: | Office Email: |
| Soc. Sec #: Last 4 Digits Weight: ☐kg ☐lbs Height: ☐cm ☐ft | Key Office Contact: |
| Date of Birth: Sex: ☐ Male ☐ Female BSA: | State LIC # NPI # DEA# |

| Clinical Diagnosis: please fax or email relevant clinical notes, labs, tests and previous medical history to expedite prior authorization | | | |
|---|---|---|---|
| Diagnosis / ICD-10: | | ☐ Mild ☐ Moderate ☐ Severe | Prior Treatment Dates: |
| Date of Diagnosis or Years with Disease: | | Is patient currently on therapy? ☐ Y ☐ N | |
| Has patient been previously treated for this condition? ☐ Y ☐ N | | Will patient terminate current therapy upon start of new prescription? ☐ Y ☐ N | |
| Is the patient taking methotrexate? ☐ Y ☐ N | Latex allergy: ☐ Y ☐ N | BMD/T-Site & Score & Date: | |
| | | TB/PPD Test: ☐ Yes ☐ No Results: | |

**MEDICATIONS AND DIRECTIONS**

| TYPE | MEDICATION | DOSE/STRENGTH | DIRECTIONS | QUANTITY | REFILL |
|---|---|---|---|---|---|
| TNF blocker | ☐ **Cimzia®** | ☐ 200 mg Starter Kit (6x200 mg PFS)<br>☐ 2 x 200 mg Prefilled Syringe | ☐ Inject 400 mg SQ once. Repeat weeks 2 & 4<br>☐ Inject 200 mg SQ once every 2 weeks<br>☐ Inject 400 mg SQ once every 4 weeks | 4 week supply | |
| | | ☐ 200 mg lyophilized powder in a single-dose vial | | | |
| | ☐ **Enbrel®** | ☐ 25 mg Prefilled Syringe<br>☐ 50 mg/ml SureClick Autoinjector<br>☐ 50 mg/ml Prefilled Syringe | ☐ Inject 25 mg twice weekly, 72-96 hours apart<br>☐ Inject 50 mg SQ once weekly<br>☐ Other _____ | 4 week supply | |
| | ☐ **Humira®** | ☐ 40 mg/0.8 ml Pen<br>☐ 40 mg/0.8 ml Prefilled Syringe | ☐ Inject 40 mg SQ every other week<br>☐ Inject 40 mg SQ once weekly | 4 week supply | |
| | ☐ **Inflectra®** | ☐ 100 mg/20 ml vial | | | |
| | ☐ **Remicade®** | ☐ 100 mg/20 ml vial | | | |
| | ☐ **Simponi®** | ☐ 50 mg/0.5 ml Prefilled Syringe<br>☐ 50 mg/0.5 ml Autoinjector | ☐ Inject 50 mg SQ once a month | 4 week supply | |
| | ☐ **Simponi Aria®** | ☐ 50 mg/4 mL single-use vial | ☐ 2 mg/kg IV over 30 minutes at weeks 0 and 4, then every 8 weeks thereafter<br>☐ 2 mg/kg IV over 30 minutes every 8 weeks | 4 week supply | |
| IL-6 Antagonist | ☐ **Actemra®** | ☐ 162 mg/0.9 ml PFS | ☐ Inject 1 Syringe SQ once weekly<br>☐ Inject 1 Syringe SQ every other week | 4 week supply | |
| | | IV Infusion: ☐ 80 mg/4 mL (20 mg/mL), ☐ 200 mg/10 mL (20 mg/mL), ☐ 400 mg/20 mL (20 mg/mL) in single-dose vials for further dilution prior to intravenous infusion | | | |
| | ☐ **Kevzara®** | ☐ 150mg prefilled syringe<br>☐ 200mg prefilled syringe | ☐ 150mg SQ once every two weeks<br>☐ 200mg SQ once every two weeks | 4 week supply | |
| IL-7A Antagonist | ☐ **Cosentyx®** | ☐ 150 mg/mL single-use Sensoready® pen<br>☐ 150 mg/mL single-use prefilled syringe<br>☐ 150 mg, lyophilized powder in a single-use vial for reconstitution | ☐ 150 mg SQ at weeks 0, 1, 2, 3, & 4 and every 4 weeks thereafter<br>☐ 150 mg SQ every 4 weeks<br>☐ 300 mg SQ every 4 weeks | 4 week supply | |
| | ☐ **Taltz®** | ☐ 80 mg/mL solution in a single-dose prefilled autoinjector.<br>☐ 80 mg/mL solution in a single-dose prefilled syringe. | ☐ 160 mg (two 80 mg injections) SQ at Week 0, followed by 80 mg SQ at weeks 2, 4, 6, 8, 10, and 12, then 80 mg SQ every 4 weeks.<br>☐ 80mg (one injection) SQ every 4 weeks | 4 week supply | |
| IL-12,23 Antagonist | ☐ **Stelara®** | ☐ 45 mg Prefilled Syringe<br>☐ 90 mg Prefilled Syringe | ☐ Inject SQ weeks 0, 4 and every 12 weeks thereafter | 4 week supply | |
| T Cell Co-stimulation Modulator | ☐ **Orencia®** | ☐ 125 mg/ml Prefilled Syringe (4)<br>☐ 250 mg/15 ml vial (IV only) | ☐ Inject 125 mg SQ once weekly<br>☐ Infuse _____mg IV every 4 weeks | ____ syringes<br>____ vials | |

| *Prescriber Signature Required* | | **Prescription is void if the number of drugs prescribed is not noted* |
|---|---|---|
| I authorize Hawaii Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process. | | |
| **PRESCRIBER SIGNATURE** | **DATE** | **NO. OF DRUGS PRESCRIBED** _____ ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 |
| **X** | | |

HAWAII SPECIALTY™ PHARMACY

# RHEUMATOLOGY REFERRAL FORM

***Please complete and attach to MDX prior Authorization form***

MDX Hawai'i

| PATIENT INFORMATION: | PHYSICIAN INFORMATION: |
|---|---|
| Patient Name: | Physician Name: |
| Address: | Address: |
| City: State: Zip: | City: State: Zip: |
| Home Phone: Alternate Phone: | Phone: Fax: |
| Email: | Office Email: |
| Soc. Sec #: Last 4 Digits Weight: ☐kg ☐lbs Height: ☐cm ☐ft | Key Office Contact: |
| Date of Birth: Sex: ☐ Male ☐ Female BSA: | State LIC # NPI # DEA# |

| Clinical Diagnosis: please fax or email relevant clinical notes, labs, tests and previous medical history to expedite prior authorization | | | |
|---|---|---|---|
| Diagnosis / ICD-10: | | ☐ Mild ☐ Moderate ☐ Severe | Prior Treatment Dates: |
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| Has patient been previously treated for this condition? ☐ Y ☐ N | | Will patient terminate current therapy upon start of new prescription? ☐ Y ☐ N | |
| Is the patient taking methotrexate? ☐ Y ☐ N | Latex allergy: ☐ Y ☐ N | BMD/T-Site & Score & Date: | |
| | | TB/PPD Test: ☐ Yes ☐ No Results: | |

## MEDICATIONS AND DIRECTIONS

| TYPE | MEDICATION | DOSE/STRENGTH | DIRECTIONS | QUANTITY | REFILL |
|---|---|---|---|---|---|
| CD20-directed cytolytic antibody | ☐ **Rituxan®** | ☐ 10 mg/ml | | | |
| PDE4 Inhibitor | ☐ **Otezla®** | ☐ Starter Pack<br>☐ 30 mg tablets | ☐ Take as directed<br>☐ Take 1 tablet twice daily | ☐ 1 pack<br>☐ 60 tablets | |
| JAK Inibitor | ☐ **Xeljanz®** | ☐ 5 mg tablets<br>☐ 11 mg ER tablets | ☐ Take 5 mg PO twice daily<br>☐ Take 11 mg PO once daily | 4 week supply | |
| rhPTH(1-34) | ☐ **Forteo®**<br>☐ **BD Ultra-Fine Pen Needles** | ☐ 600 mcg/2.4 ml Prefilled Syringe | ☐ Inject 20 mcg SQ as directed once daily | 4 week supply | |
| PTH1R agonist | ☐ **Tymlos®**<br>☐ **BD Ultra-Fine Pen Needles** | ☐ 80 mcg | ☐ 80 mcg SQ once daily | 30 days supply | |
| RANKL inhibitor | ☐ **Prolia®** | ☐ 60 mg Prefilled Syringe | ☐ Inject 60 mg SQ once every 6 months | | |
| BLyS inhibitor | ☐ **Benlysta®** | ☐ 120 mg/5mL single-dose vial<br>☐ 400 mg/20mL single-dose vial<br>☐ 200 mg/mL single-dose prefilled autoinjector<br>☐ 200 mg/mL single-dose prefilled syringe | ☐ 10 mg/kg IV at 2-week intervals for the first 3 doses and at 4-week intervals thereafter.<br>☐ 200 mg SQ once weekly | | |
| Pegylated uric acid specific enzypme | ☐ **Krystexxa®** | ☐ 8 mg/mL | ☐ 8 mg given as an intravenous infusion every two week for chronic Gout. | | |
| Bisphosphonate | ☐ **Zoledronic acid** | ☐ 5 mg in a 100 mL ready-to-infuse solution | ☐ Infuse 5mg/100mL IV over 30 minutes | | |
| | ☐ **Other** | | | | |

***Prescriber Signature Required*** ****Prescription is void if the number of drugs prescribed is not noted***

I authorize Hawaii Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

| PRESCRIBER SIGNATURE | DATE | NO. OF DRUGS PRESCRIBED _____ ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 |
|---|---|---|
| X | | |