RHEUMATOLOGY REFERRAL FORM A-C



MEDICATION









STRENGTH

162ma/0.9mL Prefilled

Star PAVILIONS CARRS | Randalls Tom Thumb-

QUANTITY

2 syringes/pens

REFILLS

Patient	nformation

Prescription

Patient Name:			DOB: _			Sex:	М	□F
Phone:	Cell Phone:			Email Address: _				
Address:		City:			State:	Zip:		
ICD-10 Diagnosis Code:		Diagnosis:						
Allergies (please note reaction):							Lat	ex
Current Medications: (list here or attach a m	edication list):							
Comorbidities: (list here or attach a list):								
,								

INSURANCE INFORMATION - FAX COPY OF PATIENT'S INSURANCE CARD - BOTH SIDES

Inject 162mg subcutaneously every other week.

DIRECTIONS

Actemra (tocilizumab)	Syringe 162mg/09mL Actemra ACTPen	☐ Inject 162mg subcutaneously once a week.	4 syringes/pens syringes/ pens
	Starter Kit 200mg/mL Prefilled Syringe	Loading Dose: Inject 400mg (2 syringes) subcutaneously at week 0, 2 and 4.	s 1 kit (6 syringes)
Cimzia (certolizumab)	200mg/mL Prefilled	Maintenance Dose: Inject 400mg (2 syringes) subcutaneously every 4 weeks.	2 syringes
Syringe		Maintenance Dose: Inject 200mg (1 syringe) subcutaneously every 2 weeks.	6 syringes
Cosentyx	150mg Sensoready Pen	Loading Dose: Inject 150mg subcutaneously once weekly at weeks 0, 1, 2, 3, and 4. Loading Dose: Inject 300mg (2 injections of 150mg) subcutaneously once weekly at weeks 0, 1, 2, 3, and 4.	4 syringes/pens 8 syringes/pens
(secukinumab)	150mg Prefilled Syringe	Maintenance dose: Starting at week 4, inject 150mg subcutaneously every 4 weeks.	1 syringe/pen 2 syringes/pens
		Maintenance dose: Starting at week 4, inject 300mg (2 injection of 150mg) subcutaneously every 4 weeks.	pens syringes/
Treatment H	listory: 🗆 New to Th	erapy Continuation of Therapy	
Hepatitis B Screeni	ng Results: HBsAg:	Anti-HBs: Anti-HBc:	
If applicable, ha	s treatment been initiated? [Yes□ No	
Tuberculosis Asses	sment Date:	egative Active TB Latent TB History of ac	ctive or latent TB
If history of active o	or latent TB:	Adequate treatment is confirmed: Ye	s 🗆 No
	Bowel Disease: Yes		
Prescriber Name: _		DEA #: NPI:	
Additional Contact	Person Name:		
Group or Hospital:_		Phone:	
Address:		Email Address: City: State	e: Zip:
Prescriber Signatur			
The prescriber is to co compliance with state	Product Substitution omply with state specific prescript e specific requirements could resu	ion requirements such as e-prescribing, state specific prescription forr	Date n, fax language, etc. Non-
Ship to Patient	Ship to Prescriber/Clinic	Pick up at Albertsons Companies Pharmacy Date M	ledication Needed:

Prescriber

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RHEUMATOLOGY REFERRAL FORM D-H



Patient Name: _







SAFEWAY ()

Š	star
_	market

_ DOB: _

PAVILIONS CARRS () Randalls Tom Thumb

Sex: M

F

_ o	Phone:	Cell Phone:	Email Address:	
ati	Address: ICD-10 Diagnosis Code:	Digan	City: State: _	Zip:
Patient formatic	Allergies (please note read	etion):	osis:	Latex
Patient Information				
	Comorbidities: (list here or	attach a list):		
	II	ISURANCE INFORMATION - FAX COPY	OF PATIENT'S INSURANCE CARD - BOTH	SIDES
	MEDICATION	STRENGTH	DIRECTIONS	QUANTITY REFILLS
		50mg/mL Sureclick Auto-injector		
	Enbrel (etanercept)	50mg/mL Prefilled Syringe	☐ Inject 50mg subcutaneously once a week.	4 syringes/pens
	(ctanoloopt)	25mg/0.5mL Prefilled Syringe	☐ Inject 25mg subcutaneously twice a week.	8 syringes/vials
u o	Humira (adalimumab) Patient weight:	10kg to < 15kg 10mg/0.1 mL Citrate-free Prefilled Syringe 10mg/0.2 mL Prefilled Syringe	☐ Inject 10mg subcutaneously every OTHER week.	
Prescription Information		15kg to < 30kg 20mg/0.2 mL Citrate-free Prefilled Syringe 20mg/0.4 mL Prefilled Syringe	☐ Inject 20mg subcutaneously every OTHER week.	2 syringes/pens 4 syringes/pens
a =	Patient weight:kg	≥ 30kg 40mg/0.4 mL Citrate-free Pen 40mg/0.8 mL Pen 40mg/0.4 mL Citrate-free Prefilled Syringe 40mg/0.8 mL Prefilled Syringe	☐ Inject 40mg subcutaneously every OTHER week. ☐ Inject 40mg subcutaneously every week.	
	Hepatitis B Screening R If applicable, has tre Tuberculosis Assessme If history of active or lat	_ 3	Anti-HBc:	
	•	Fibisedse. Tes Lino		
	State License #:	DEA #:	NPI:	
	Group or Hospital:	son Name:	Phone:	
Prescriber nformation	Fax:	Email Ad	dress:City:State:	7in:
	Address.		Gity State	2ιρ
Prescriber nformation	<u>Prescriber Signature:</u>	Product Substitution Permitted	Dispensed as Written	Dete
_			as e-prescribing, state specific prescription form, fax la	Date Inguage, etc. Non-
> uo	Ship to Patient	Ship to Prescriber/Clinic Pick up at A	lbertsons Companies Pharmacy Date Medica	tion Needed:
Delivery nformation	Confidentiality Warning: T use of the individual or en dissemination, distribution	the information contained in this facsimile messag tity to which it is addressed. If the reader of this m	ge is privileged and confidential information intended nessage is not the intended recipient, you are hereby ation contained herein is strictly prohibited. If you have	only for the review and notified that any disclosure,

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RHEUMATOLOGY REFERRAL FORM I-N



Comorbidities: (list here or attach a list):









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Prescription

INSURANCE INFORMATION - FAX COPY OF PATIENT'S INSURANCE CARD - BOTH SIDES

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
Kevzara®	☐ 150mg/1.14mL Pen ☐ 150mg/1.14mL Prefilled Syringe ☐ 200mg/1.14mL Pen ☐ 200mg/1.14mL Prefilled Syringe	☐ Inject 200mg subcutaneously every two weeks. ☐ Inject 150mg subcutaneously every two weeks.	2 syringes/pens	
☐ Kineret (anakinra)	100mg/0.67mL Prefilled Syringe	Inject 100mg subcutaneously every 24 hours.	28 syringes	

Hepatitis B Screening Results: HBsA	_		i-HBc:	
Tuberculosis Assessment Date:	☐ Negative ☐ Active	e TB Latent TB	☐ History of active or latent TB	
If history of active or latent TB: History of Irritable Bowel Disease:		Adequate treatment is	confirmed: □Yes □No	
Prescriber Name:				
State License #:Additional Contact Person Name:			NPI:	
Group or Hospital:			Phone:	
Fax:				
Address:		City:	State: Zip:	

□ Continuation of Therapy

Dispensed as Written

Prescriber Information

Prescriber Signature:

Selivery formation

The prescriber is to comply with state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-

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Date

Livonia, MI 48150 • NCPDP 2374445 • NPI 122534322

Product Substitution Permitted

compliance with state specific requirements could result in outreach to the prescriber.

Treatment History: ☐ New to Therapy

RHEUMATOLOGY REFERRAL FORM O



Comorbidities: (list here or attach a list):









Information

Stary PAVILIONS CARRS () Sex: M Patient Name: DOB: Phone: Cell Phone: Email Address: Address: _ Zip: ICD-10 Diagnosis Code: Diagnosis: Allergies (please note reaction): ___Latex Current Medications: (list here or attach a medication list):

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILL
Olumiant®	2mg Tablets	Take one tablet by mouth once daily.	30 tablets	
	250mg Vial (IV use only)	Loading Dose: Injectmg via intravenous infusion at 0, 2 and 4 weeks.	3 vials	
Orencia (abatacept)		Injectmg via intravenous infusion every 4 weeks.	vials	
	☐ 125mg/mL Prefilled Syringe☐ 125mg/mL Auto-injector	☐ Adults and children ≥ 50 kg: Inject 125mg subcutaneously once weekly.	4 syringes/ autoinjectors	
Otrexup (methotrexate)	7.5mg/0.4mL Auto-injector 10mg/0.4mL Auto-injector 12.5mg/0.4mL Auto-injector 15mg/0.4mL Auto-injector 17.5mg/0.4mL Auto-injector 20mg/0.4mL Auto-injector 22.5mg/0.4mL Auto-injector	Inject one autoinjector subcutaneously once weekly.	4 autoinjectors	
Treatment His	tory: ☐ New to Therapy	□ Continuation of Therapy		
		• •		
Hepatitis B Screening	Results: HBsAg:	Anti-HBs: Anti-HBc:		
Hepatitis B Screening	Results: HBsAg: = 0	Anti-HBs: Anti-HBc:		
Hepatitis B Screening If applicable, has tr Tuberculosis Assessm	Results: HBsAg: = 0	Anti-HBs: Anti-HBc: o Active TB Latent TB History of active	ve or latent TB	
Hepatitis B Screening If applicable, has tr Tuberculosis Assessm If history of active or lo	Results: HBsAg:	Anti-HBs: Anti-HBc: o Active TB Latent TB History of active	ve or latent TB	
Hepatitis B Screening If applicable, has tr Tuberculosis Assessm If history of active or lo History of Irritable Bow Prescriber Name: State License #:	Results: HBsAg: Deatment been initiated? Yes Neent Date: Negative Disease: Yes No	Anti-HBs: Anti-HBc: O	ve or latent TB	
Hepatitis B Screening If applicable, has tr Tuberculosis Assessm If history of active or lo History of Irritable Bow Prescriber Name: State License #: Additional Contact Pe	Results: HBsAg: Peatment been initiated? Yes Negative Negative Disease: Yes No	Anti-HBs: Anti-HBc: O	ve or latent TB	
Hepatitis B Screening If applicable, has tr Tuberculosis Assessm If history of active or la History of Irritable Bow Prescriber Name: State License #: Additional Contact Pe Group or Hospital: Fax:	Results: HBsAg: Peatment been initiated? Yes Neet Negative attent TB: Negative No Peatment Date: No Peatment	Anti-HBs: Anti-HBc: O	ve or latent TB	
Hepatitis B Screening If applicable, has tr Tuberculosis Assessm If history of active or la History of Irritable Bow Prescriber Name: State License #: Additional Contact Pe Group or Hospital: Fax:	Results: HBsAg: Peatment been initiated? Yes Neet Negative attent TB: Negative No Peatment Date: No Peatment	Anti-HBs: Anti-HBc: O	ve or latent TB	
Hepatitis B Screening If applicable, has tr Tuberculosis Assessm If history of active or la History of Irritable Bow Prescriber Name: State License #: Additional Contact Pe Group or Hospital: Fax:	Results: HBsAg: Deatment been initiated? Yes Neent Date: Negative attent TB: Yes No	Anti-HBs: Anti-HBc: O	ve or latent TB	
Hepatitis B Screening If applicable, has tr Tuberculosis Assessm If history of active or lot History of Irritable Bow Prescriber Name: State License #: Additional Contact Pe Group or Hospital: Fax: Address: Prescriber Signature: The prescriber is to comp	Results: HBsAg:	Anti-HBs: Anti-HBc: O	ve or latent TB	Date

in error, please immediately notify sender by telephone, and destroy the original documents.

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RHEUMATOLOGY REFERRAL FORM P-R









vials

vials

Specialty Car	•	market ,	Traillions,				
Patient Name:			DOB:			Sex: 1	м 🔲 ғ
Phone:	Cell Phone:			Email Address: _			
Address:		City: _			_ State:	Zip:	
Alleraies (please note reacti	on):	Diagnosis:					Latex
Current Medications: (list he	re or attach a medication list):						
Comorbidities: (list here or c	ttach a list):						
INS	SURANCE INFORMATION - FA	AX COPY OF PATI	ENT'S INSU	RANCE CARE	- BOTH S	SIDES	
MEDICATION	SURANCE INFORMATION - FA	AX COPY OF PATI	ENT'S INSU		O-BOTHS	SIDES QUANTITY	REFILLS
		AX COPY OF PATI			D-BOTHS		REFILLS
	STRENGTH	AX COPY OF PATI			D-BOTHS		REFILLS
	STRENGTH 7.5mg/0.15 Auto-injector	AX COPY OF PATI			D-BOTHS		REFILLS
	STRENGTH 7.5mg/0.15 Auto-injector 10mg/0.2mL Auto-injector	AX COPY OF PATI			D-BOTHS		REFILLS
	STRENGTH 7.5mg/0.15 Auto-injector 10mg/0.2mL Auto-injector 12.5mg/0.25mL Auto-injector	AX COPY OF PATI					REFILLS

22.5 mg/0.45mL Auto-injector 25mg/0.5mL Auto-injector **Prescription** 27.5mg/0.55mL Auto-injector 30mg/0.6mL Auto-injector Loaḍing Dose: Administer ___ Remicade mg/kg) intravenously at (infliximab) 0, 2 and 6 weeks. Inflectra 100mg Vial (infliximab-dyyb) Maintenance Dose: Administer __ _mg/kg) Patient weight: intravenously every_ **Treatment History:** □ **New to Therapy** □ Continuation of Therapy

Hepatitis B Screening Results: HBsAg:	Aı	nti-HBs:	Anti-	-HBc:
If applicable, has treatment been initi	ated? Yes No			
Tuberculosis Assessment Date:	□ Negative □	Active TB	Latent TB	☐ History of active or latent TB
If history of active or latent TB:		Adequ	ate treatment is c	confirmed: Yes No
History of Irritable Bowel Disease:	Yes □No			

DEA #:

ber tion	Additional Contact Person Name: Group or Hospital:
. =	Fax:
5 č	Address:
es orr	
Pre nfo	Prescriber Signature:

Prescriber Name:

State License #:

Email Address: City: State:

The prescriber is to comply with state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Noncompliance with state specific requirements could result in outreach to the prescriber.

Ship to Prescriber/Clinic Ship to Patient

Product Substitution Permitted

Pick up at Albertsons Companies Pharmacy Date Medication Needed:

Dispensed as Written

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Date

E-Scribe Information:

Phone: 877-770-4633 | Fax: 877-771-4633 www.albertsons.com/specialtycare

RHEUMATOLOGY REFERRAL FORM S-Z









SAFEWAY ()

Prescription

Xeljanz XR

(tofacitinib) Other Medication 11mg XR Tablet

Specialty	Care SPECIALTY PHARMACY	shaws stary PAVILIONS CARRS ()	ndalls. Tom Thumb.	
Patient Name:	Call Phone:	DOB: Email Address:	Sex: M	F
Address:	e: reaction):	City: Sta	ate: Zip:	
	re or attach a list):	- FAX COPY OF PATIENT'S INSURANCE CARD - BO		
MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
Simponi (golimumab)	50mg/0.5mL SmartJect Auto-injector 50mg/0.5mL Prefilled Syringe	Inject 50mg subcutaneously once monthly.	1 syringe/pen 3 syringes/pens	
□ Taltz (ixekizumab)	80mg/mL Auto-injector	Inject 160mg subcutaneously at weeks 2, 4, 6, 8, 10 and 12; then inject 80mg subcutaneously every 4 weeks. Inject 160mg subcutaneously once, followed by 80mg subcutaneously every 4 weeks.	4 syringes/pens	2
		☐ Inject 80mg subcutaneously every 4 weeks.	1 syringe/pen 2 syringes/pens	
		Take 1 tablet by mouth twice daily.	60 tablets	
∐ Xeljanz (tofacitinib)	5mg Tablet	Take 1 tablet by mouth once a day (renal/hepatic impairment).	30 tablets	

Treatment History: ☐ New	to Therapy	□ Cont	tinuation of	Therapy
Hepatitis B Screening Results:☐ HBsAg	:	Anti-HBs:		i-HBc:
If applicable, has treatment been in	tiated? 🗌 Yes 🗆 1	No		
Tuberculosis Assessment Date:	□ Negative	Active TB	Latent TB	☐ History of active or latent TB
If history of active or latent TB:		Adequ	uate treatment is (confirmed: Yes No
History of Irritable Bowel Disease:]Yes □ No			
Prescriber Name:				
State License #:		DEA #:		
Additional Contact Person Name: Group or Hospital:				
Fax:		_ Email Address:	·	
Address:			City:	State: Zip:

The prescriber is to comply with state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-

Take 1 tablet by mouth once daily.

Prescriber

Ship to Patient

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Pick up at Albertsons Companies Pharmacy Date Medication Needed:

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E-Scribe Information:

Date

Product Substitution Permitted

compliance with state specific requirements could result in outreach to the prescriber.

Ship to Prescriber/Clinic

30 tablets