RHEUMATOLOGY REFERRAL FORM

Email: info@benevaspecialty.com
Fax: 805.371.0701
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Beneva Specialty Pharmacy
375 Rolling Oaks Dr., Suite 150
Thousand Oaks, CA 91361
NPI: 1316428808

Beneva SPECIALTY PHARMACY

Ship to: ☐ Patient ☐ Prescriber ☐ Other _____

PATIENT INFORMATION

Patient Name (Last, First): _____ DOB: _____ Gender: ☐ Male ☐ Female
Address: _____ City: _____ State: _____ Zip: _____
SSN: _____ Allergies: _____ ☐ NKDA
Phone: _____ Alternate Phone: _____
Email: _____ Preferred Contact: ☐ Phone ☐ Email
Emergency Contact: _____
Relationship to Patient: _____ Phone: _____

INSURANCE INFORMATION: Please fax a copy of prescription and insurance cards with this form (front and back)

CLINICAL INFORMATION

Diagnosis (ICD-10): Date of Diagnosis: _____

☐ M06.9 Rheumatoid Arthritis, unspecified
☐ M08.00 Unspecified Juvenile RA of unspecified site
☐ L40.59 Other Psoriatic Arthropathy
☐ M45.9 Ankylosing Spondylitis of unspecified sites in spine
☐ L40.52 Psoriatic Arthritis
☐ Other ICD10: _____

Treatment Status: ☐ New to Therapy ☐ Continuation of Therapy **Date of Last Treatment:** _____ **Needs By:** _____

BSA: _____ **Weight:** _____ lb/kg **Height:** _____ in/cm **TB Result:** _____ **Date:** _____

Therapy Tried and Failed (please list medication and duration): _____
Response: ☐ Intolerant ☐ Ineffective ☐ Contraindicated ☐ Side effects ☐ Other: _____

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QTY	REFILLS
☐ **Actemra**	☐ 162 mg/0.9mL PEN ☐ 162 mg/0.9mL PFS	**For patients weighing < 100kg** ☐ Inject 162 mg SQ every other week **For patients weighing ≥ 100kg** ☐ Inject 162 mg SQ every week	2 4	_____ _____
☐ **Cimzia**	☐ 200 mg/1mL Starter Kit ☐ 200 mg/1mL PFS	☐ **Initial Dose:** Inject 400 mg SQ initially, then repeat dose at week 2 and 4 ☐ **Maintenance Dose:** Inject 400 mg SQ every 4 weeks	6 PFS 2PFS	None _____
☐ **Cosentyx**	☐ 150 mg/mL PFS ☐ 150 mg/mL Sensoready Pen ☐ 150 mg/mL (2pk) PFS ☐ 150 mg/mL (2-pen pk) Sensoready Pen ☐ 300 mg/mL PFS ☐ 300 mg/mL Unoready Pen	☐ **Initial Dose:** Inject ☐ 150 mg ☐ 300 mg SQ weekly at weeks 0, 1, 2, 3, and 4 ☐ **Maintenance Dose:** Inject ☐ 150 mg ☐ 300 mg SQ every 4 weeks	5 week supply 4 week supply	None _____
☐ **Enbrel**	☐ 50 mg/mL Mini-Cartridge ☐ 50 mg/mL PFS ☐ 50 mg/mL SureClick Autoinjector	☐ Inject 50 mg SQ every week	4	_____
☐ **Humira Citrate Free**	☐ 40 mg/0.4mL PEN ☐ 40 mg/0.4mL PFS	☐ Inject 40 mg SQ every week ☐ **Alternate Dose:** Inject 40 mg SQ every week ☐ **Citrate Free 80 mg/0.8mL PEN:** Inject 80 mg SQ every week	2 4 2	_____ _____ _____
☐ **Otezla**	☐ Titrate Starter Pack (28 days) ☐ 30 mg Tablet	☐ **Initial Titration Dose:** Take as directed per package instructions ☐ **Maintenance Dose:** Take 30 mg by mouth twice a day	1 pack 60 tabs	None _____
☐ **Rinvoq**	☐ 15 mg ER	☐ Take 1 tablet by mouth every day	30 tabs	_____

Complete signature on next page ➡

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☐ **Simponi**	☐ 50 mg/0.5mL SmartJect Autoinjector ☐ 50 mg/0.5mL PFS	☐ Inject 50 mg SQ once per month	1	_____
	☐ Simponi Aria 50 mg/4mL Single Use Vial	☐ **Initial Dose:** Inject 2 mg/kg IV at weeks 0 and 4 ☐ **Maintenance Dose:** Inject 2 mg/kg IV every 8 weeks thereafter	2 doses _____	None _____
☐ **Stelara**	☐ 45 mg/0.5mL PFS ☐ 90 mg/mL PFS	☐ **Initial Dose:** Inject ☐ 45 mg ☐ 90 mg SQ initially and 4 weeks later, followed by every 12 weeks ☐ **Maintenance Dose:** Inject ☐ 45 mg ☐ 90 mg SQ every 12 weeks	2 1	None _____
☐ **Tremfya**	☐ 100 mg/mL Single-Dose PFS ☐ 100 mg/mL Autoinjector	☐ **Initial Dose:** Inject 100 mg SQ at week 0 and on week 4 ☐ **Maintenance Dose:** Inject 100 mg SQ every 8 weeks	1 1	1 _____
☐ **Xeljanz**	☐ 5 mg tablet	☐ Take 1 tablet by mouth twice a day	60 tabs	_____
☐ **Xeljanz XR**	☐ 11 mg tablet	☐ Take 1 tablet by mouth every day	30 tabs	_____
☐ Other (drug and strength): _____		_____	_____	_____

PRESCRIBER INFORMATION

Prescriber Name: _____ NPI: _____ DEA: _____ LIC#: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____
Contact Person: _____ Phone:_____

PRESCRIBER SIGNATURE (DO NOT STAMP)

"Dispense as Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / May No Substitute Prescriber's Signature: _____ Date: _____	May Substitute / Product Selection Permitted / Substitution Permissible Prescriber's Signature: _____ Date: _____

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing above, I hereby authorize Beneva Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA requests as my signature.

End of Referral Form