AcariaHealth™
Specialty Pharmacy

Phone: 800.511.5144 • Fax: 877.541.1503

Date Shipment Needed: _____ Ship To: ☐ Patient ☐ Prescriber
☐ Nursing needed; ☐ Training needed ▶ All the supplies including syringes and needles will be dispensed if needed.

BIOSIMILAR RHEUMATOLOGY NON-IV REFERRAL FORM

PATIENT INFORMATION

Patient Name:		DOB:	Sex: ☐ M ☐ F ☐ Other:	Weight:	☐ lbs. ☐ kg.
SSN:	Phone:	Allergies:			
Address:		City:	State:	Zip:	
Emergency Contact:		Phone:	☐ **Additional Information Attached**		

PRESCRIBER INFORMATION

Prescriber:		NPI:	DEA:	State Lic:
Supervising Physician:		Practice Name:		
Address:		City:	State:	Zip:
Phone:	Fax:	Key Office Contact:		Phone:

DIAGNOSIS INFORMATION / MEDICAL ASSESSMENT

Primary Diagnosis: ☐ M06.9 Rheumatoid Arthritis ☐ L40.54; L40.59 Psoriatic Arthritis ☐ M08.00 Unspecified Juvenile Rheumatoid Arthritis ☐ M08.3 Juvenile Rheumatoid Polyarthritis (Seronegative)
☐ M08.20 Juvenile Idiopathic Arthritis ☐ M45.9 Ankylosing Spondylitis ☐ M33.20 Polymyositis ☐ M81.0 Osteoporosis ☐ M15.0; M15.9 Osteoarthritis ☐ Other:_____

- Has patient been treated *previously* for this condition? ☐ Yes ☐ No Is patient *currently* on therapy? ☐ Yes ☐ No Please list medication(s) and treatment duration:
  _____
- Will patient stop taking the above medication(s) before starting the new medication? ☐ Yes ☐ No If *yes*, how long should patient wait before starting the new medication?
  _____
- Other medications patient is currently taking including OTC medications with dosage and direction (or fax medication profile):
  _____
- Has patient received a **Quatiferon gold**, **Tspot** or **PPD (tuberculosis) Skin Test**? ☐ Yes ☐ No Date: _____ Results: ☐ Negative ☐ Positive
  Prior to initiating treatment and periodically during therapy, patient should be evaluated for active tuberculosis and tested for latent infection

INSURANCE INFORMATION

☐ **Please attach front and back of patient's insurance card (medical and prescription)**

COPAY CARD ENROLLMENT

☐ **Please check if enrolling in copay card** **Copay ID:**

PRESCRIPTION INFORMATION

Abrilada® ☐ 40 mg/0.8 mL Pen *OR* ☐ 40 mg/0.8 mL Syringe
☐ 40 mg/0.8 mL Pen every week OR ☐ 40 mg/0.8 mL Syringe every other week
QTY: _____ | Refills: _____

Amjevita® ☐ 40 mg/0.8 mL Pen *OR* ☐ 40 mg/0.8 mL Syringe
☐ 40 mg SQ every week ☐ 40 mg SQ every other week
QTY: _____ | Refills: _____

Cyltezo® *(Adalimumab-adbm)* ☐ 40 mg/0.8 mL Pen *OR* ☐ 40 mg/0.8 mL Syringe
☐ 40 mg SQ every week ☐ 40 mg SQ every other week
QTY: _____ | Refills: _____

Hadlima® ☐ 40 mg/0.4 mL Pen *OR* ☐ 40 mg/0.4 mL Prefilled Syringe *OR* ☐ 40 mg/0.8 mL Pen *OR* ☐ 40 mg/0.8 mL Syringe
☐ 40 mg SQ every week ☐ 40 mg SQ every other week
QTY: _____ | Refills: _____

Hulio® *(Adalimumab-fkjp)* ☐ 40 mg/0.8 mL Pen *OR* ☐ 40 mg/0.8 mL Syringe
☐ 40 mg SQ every week ☐ 40 mg SQ every other week
QTY: _____ | Refills: _____

Humira® ☐ 40 mg/0.4 mL Pen CF ☐ 40 mg/0.4 mL Prefilled Syringe CF ☐ **Enroll in Humira Complete Program**
☐ 20 mg/0.4 mL Prefilled Syringe CF ☐ 10 mg/0.2 mL Prefilled Syringe CF
☐ 40 mg SQ every other week ☐ 20 mg SQ every other week ☐ 10 mg SQ every other week ☐ 40 mg SQ every week
QTY: _____ | Refills: _____
☐ Alternate Dose: _____
QTY: _____ | Refills: _____

Hyrimoz® *(Adalimumab-adaz)* ☐ 40 mg/0.4 mL Pen *OR* ☐ 40 mg/0.4 mL Syringe
☐ 40 mg SQ every week ☐ 40 mg SQ every other week
QTY: _____ | Refills: _____

Idacio® *(Adalimumab-aacf)* ☐ 40 mg/0.8 mL Pen *OR* ☐ 40 mg/0.8 mL Syringe
☐ 40 mg SQ every week ☐ 40 mg SQ every other week
QTY: _____ | Refills: _____

Yusimry® ☐ 40 mg/0.8 mL Pen
☐ 40 mg SQ every week ☐ 40 mg SQ every other week
QTY: _____ | Refills: _____

Yuflyma® ☐ 40 mg/0.4 mL Pen *OR* ☐ 40 mg/0.4 mL Syringe
☐ 40 mg SQ every week ☐ 40 mg SQ every other week
QTY: _____ | Refills: _____

☐ **Other:** _____
QTY: _____ | Refills: _____

Prescriber's Signature: _____ ☐ DAW (Dispense as Written) **Date:** _____

Prescriber certifies that this referral form contains an original signature and is signed by the treating prescriber. NO STAMPED SIGNATURES WILL BE ACCEPTED. Where required by law, send electronic prescription or on official state prescription blank. In the event requested agent is not available through AcariaHealth, this prescription shall be forwarded to an eligible pharmacy.