AcariaHealth™
Specialty Pharmacy

Phone: 866.892.1580 • Fax: 866.892.2363

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 Polyarticular Juvenile Rheumatoid Arthritis ☐M08.00 Juvenile Idiopathic Arthritis ☐L40.0 Plaque Psoriasis ☐M45.9 Ankylosing Spondylitis ☐M33.20 Polmyositis ☐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

PRESCRIPTION INFORMATION

Humira® ☐40 mg/ 0.4 mL Pen CF ☐40 mg/ 0.4 mL Prefilled Syringe CF ☐20 mg/ 0.4 mL Prefilled Syringe CF ☐10 mg/ 0.2 mL Prefilled Syringe CF **☐Enroll in Humira Complete Program**
☐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:_____

Amjevita ☐40mg/0.8ml Pen ☐40mg/0.8ml syringe
☐40mg SQ every week ☐40mg SQ every other week QTY:_____ Refills:_____

Cyltezo ☐40mg/0.8ml syringe
☐40mg SQ every week ☐40mg SQ every other week QTY:_____ Refills: _____

Hulio ☐40mg/0.8ml pen ☐40mg/0.8ml syringe
☐40mg SQ every other week ☐40mg SQ every week QTY: _____ Refills: _____

Idacio ☐40mg/0.8ml pen ☐40mg/0.8ml syringe
☐40mg SQ every week ☐ 40mg SQ every other week QTY: _____ Refills: _____

Yusimry ☐40mg/0.8ml syringe
☐40mg SQ every other week ☐ 40mg SQ every week QTY: _____ Refills: _____

Yuflyma ☐40mg/0.4ml pen ☐40mg/0.4ml syringe ☐40mg/0.4ml syringe with safety guard
☐ 40mg SQ every week ☐ 40mg SQ every other week 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 prescription on official state prescription blank. In the event requested agent is not available through AcariaHealth, this prescription shall be forwarded to an eligible pharmacy.

09.05.2023