To expedite processing, please send the following information with prescription.

- ☐ Referral Form
- ☐ Demographic Sheet
- ☐ Most Recent Clinical Notes
- ☐ List of Tried and Failed Meds (Including other Biologics)
- ☐ Prescription Insurance Card (Front & Back)

Bio-Coordinator or Primary Point of Contact at Clinic:

Name: ____________________

Email: ____________________

Direct Phone Line: ____________________

Cell (optional, but preferred): ____________________

Genefic Specialty Pharmacy
2577 Mall Road, Suite B
Florence, AL, 35630

Phone: (833) 928-7660
Fax: (833) 928-7661
Website: GeneficRx.com

Faxed prescriptions will only be accepted from a prescriber. Patients must bring an original prescription to the pharmacy, and cannot fax these referral forms to Genefic Specialty Pharmacy.

Rheumatology Enrollment Form A - H

Prescriber:	**NPI:**
Supervising Physician:	**NPI:**
Address:	**Tax ID:**
Phone:	Fax:
Contact:	

PATIENT INFORMATION

Name:	☐ M ☐ F ☐ Trans M ☐ Trans F ☐ Other	DOB: _____/_____/__________	SS#: _____-_____-__________
Street:	City:	State:	ZIP:
Phone:	Alt. Phone:	☐ English ☐ Spanish ☐ Other: ________	Wt.: ________ Ht.: ________

PRESCRIPTION

Has the patient received a loading dose/starter kit? ☐ **Yes Start Date:** ____/____/______ ☐ **No** **SHIP TO:** ☐ **Patient's Home** ☐ **Doctor's Office** ☐ **Other:** ____________

Drug		Directions & Quantity	Refills
Actemra®	☐ ACTPen® ☐ Pre-filled Syringe ☐ Vials ☐ 80 mg ☐ 200 mg ☐ 400 mg	☐ **IV:** Infuse ______ mg **OR** _____ mg/kg via IV every 4 weeks (Quantity: ___) ☐ **SQ:** Inject 162 mg SQ every **other** week (Quantity: 2) ☐ **SQ:** Inject 162 mg SQ every week (Quantity: 4)	
Cimzia®	☐ Pre-filled Syringe ☐ Vials	☐ **INITIAL:** Inject 400 mg SQ at Day 0, Day 14, and Day 28 (Quantity: 6) ☐ **MAINTENANCE:** Inject 400 mg SQ every 4 weeks (Quantity: 2) ☐ **MAINTENANCE:** Inject 200 mg SQ every 2 weeks (Quantity: 2)	
Enbrel®	☐ SureClick Pen ☐ Mini® with AutoTouch® ☐ Pre-filled Syringe	☐ Inject 50 mg SQ every week (Quantity: 4)	
Humira® ***Citrate Free***	☐ Uveitis Starter Kit ☐ Pen ☐ Pre-filled Syringe	☐ **UVEITIS INITIAL:** Inject 80 mg SQ on Day 1, 40 mg on Day 8, then 40 mg every **other** week (Quantity: 3) ☐ **MAINTENANCE:** Inject 40 mg SQ every **other** week (Quantity: 2) ☐ **MAINTENANCE:** Inject 40 mg SQ weekly (Quantity: 4)	
	☐ Pen	☐ **MAINTENANCE:** Inject 80 mg SQ every **other** week (Quantity: 2)	

MEDICAL INFORMATION

*****PLEASE FAX COPY OF PRESCRIPTION/MEDICAL CARD, FRONT AND BACK, AS WELL AS ANY CLINICAL NOTES REGARDING THERAPY*****

PREVIOUS THERAPIES:	**Tried & Failed (Duration):**	**Not Tolerated:**	**Contraindication:**
☐ Methotrexate	☐ (__________________)	☐	______________________________
☐ Plaquenil	☐ (__________________)	☐	______________________________
☐ Naproxen / Aleve	☐ (__________________)	☐	______________________________
☐ Tramadol	☐ (__________________)	☐	______________________________
☐ Enbrel	☐ (__________________)	☐	______________________________
☐ Humira	☐ (__________________)	☐	______________________________
☐ Cimzia	☐ (__________________)	☐	______________________________
☐ __________________	☐ (__________________)	☐	______________________________
☐ __________________	☐ (__________________)	☐	______________________________

☐ H20.9 Unspecified Iridocyclitis
☐ H20.0 Iridocyclitis (Uveitis), Unspecified Acute and Subacute
☐ M06.9 Rheumatoid Arthritis, Unspecified
☐ M05.9 Rheumatoid Arthritis with Rheumatoid Factor, Unspecified
☐ M31.6 Other Giant Cell Arteritis
☐ M06.09 Rheumatoid Arthritis without Rheumatoid Factor, multiple sites
☐ M31.5 Giant Cell Arteritis with Polymyalgia Rheumatica
☐ M05.79 Rheumatoid Arthritis with rheumatoid factor of mult. sites w/o organ or system involvement
☐ D89.83___ Cytokine Release Syndrome, Grade___
☐ Other: ____

Date of Diagnosis: _____/_____/__________ **Allergies:**____

Active TB is ruled out: ☐ Yes ☐ No Date: ____/____/________ Hep B ruled out/treated: ☐ Yes ☐ No Date: ____/____/________

Additional Clinical Information:

INJECTION TRAINING

☐ Patient has received pen and injection training ☐ Physician's office to provide injection training ☐ Genefic to coordinate injection training

PRESCRIBER SIGNATURE

To Prescriber: By signing this form and utilizing our services, you are also authorizing Genefic Specialty Pharmacy to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies, and co-pay assistance foundations.

Prescriber: **Date**: ________/________/____________

CONFIDENTIALITY NOTICE

IMPORTANT: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, proprietary or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.