ADVANCED PHARMACY
& RESPIRATORY CARE
SOLUTIONS

"PERSONALIZED SPECIALTY HEALTHCARE"
26611 CABOT RD.
LAGUNA HILLS, CA 92653

PSORATIC/OSTEOARTHRITIS/OSTEOPEROSIS REFERRAL

PATIENT INFORMATION	PHYSICIAN INFORMATION
PATIENT NAME:	PHYSICIAN NAME:
DOB: SEX: ☐ M ☐ F	LIC# NPI:
ADDRESS:	ADDRESS:
CITY/STATE/ZIP	CITY/STATE/ZIP:
PHONE:	PHONE FAX:
ALT PHONE:	OFFICE CONTACT : EXT:

INSURANCE INFORMATION:	
PRIMARY INSURANCE:	SECONDARY INSURANCE:
SUBSCRIBER:	SUBSCRIBER:
ID#:	ID#:
GROUP POLICY:	GROUP POLICY:
PHONE:	PHONE:
EMPLOYER:	EMPLOYER:

PRESCRIPTION:	DOSE/DIRECTIONS:
STELARA® (USTEKINUMAB)	☐45 MG/0.5 ML IN A SINGLE-USE PRE-FILLED SYRINGE ☐ 90 MG/1 ML IN A SINGLE-USE PRE-FILLED SYRINGE ☐45 MG/0.5 ML IN A SINGLE-USE VIAL ☐90 MG/1 ML IN A SINGLE-USE VIAL SIG: _____ _____REFILL
EUFLEXXA® (SODIUM HYALURONATE)	☐ 20-MG/2ML PRE-FILLED SYRINGE QUANTITY _____ SIG: ____ Q ____ WEEKS _____ REFILLS
HYALGAN® (SODIUM HYALURONATE)	☐ 20-MG/2ML PRE-FILLED SYRINGE ☐20-MG/2ML SINGLE DOSE VIAL QUANTITY _____ SIG: ____ Q ____ WEEKS _____ REFILLS
ORTHOVISC® (HIGH MOLECULAR WEIGHT HYALURONAN)	☐ 30MG/2ML PRE-FILLED SYRINGE SIG: _____ Q _____ REFILLS_____
SYNVISC® (HYLAN G-F 20)	☐ SYNVISC® 16MG/2ML PRE-FILLED SYRINGE ☐ SYNVISC ONE™ 48MG/6ML PRE-FILLED SYRINGE SIG: _____ Q _____ REFILLS_____
SUPARTZ® (SODIUM HYALURONATE)	☐ SUPARTZ® 25MG/2.5ML PRE-FILLED SYRINGE SIG: _____ Q _____ REFILLS_____
PROLIA® (DENOUMAB)	☐ 60MG PRE-FILLED SYRINGE SIG: _____ Q _____MONTHS _____REFILLS
XGEVA® (DENOUMAB)	☐120 MG/1.7 ML (70 MG/ML) SINGLE-USE VIAL SIG: _____MG/_____ML Q _____WEEKS ☐ SMARTJECT ☐ PREFILLED SYRINGE
(WRITE IN ADDITIONAL RX)	

DIAGNOSIS/STATEMENT OF MEDICAL NECESSITY: (PLEASE INCLUDE ALL RELEVANT DOCUMENTATION WHEN FAXING)

SIGNATURE: _____ DATE: _____

FAX TO 949-582-6111