ADVANCED PHARMACY
& RESPIRATORY CARE
SOLUTIONS

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

RHEUMATOLOGY 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:
ACTEMRA® (TOCILIZUMAB)	☐80 MG PER 4 ML (3) ☐ 200 MG PER 10 ML (3) ☐400 MG PER 20 ML (3) SIG: ______________MG IVQ _______DAYS _______REFILL
CIMIZIA® (CEROLIZUMAB PEGOL)	200 MG ☐SYRINGE OR ☐LYOPHILIZED PWDR QUANTITY _____ SIG: ____ Q ____ WEEKS _________ REFILLS
ENBREL® (ETANERCEPT)	☐ENBREL 50-MG/ML SURECLICK ☐ ENBREL 50-MG/ML PREFILLED SYRINGE ☐ ENBREL 25-MG MULTIUSE VIAL ☐ ENBREL 25-MG/0.5-ML PREFILLED SYRINGE SIG: _________MG Q ______DAYS ______REFILLS
HUMIRA® (ADALIMUMAB)	☐40 MG/0.8 ML IN A SINGLE-USE PREFILLED PEN (HUMIRA PEN) ☐40 MG/0.8 ML IN A SINGLE-USE PREFILLED GLASS SYRINGE ☐20 MG/0.4 ML IN A SINGLE-USE PREFILLED GLASS SYRINGE SIG: ______ Q _____WEEKS _____REFILLS
ORENCIA® (ABATACEPT)	SIG: ______MG IV OVER _________MINS Q ___________WEEKS _____________REFILLS
REMICADE® (INFLIXIMAB)	☐ INTRODUCTION DOSE _________MG/KG _____MG IV Q _______WEEKS ☐ MAINTAINANCE DOSE _____MG/KG ____MG IV Q ___ WEEKS
RUTUXAN® (RITUXIMAB)	SIG: ______MG IV OVER _______HRS Q ________WEEKS _________REFILLS
SIMPONI™ (GOLIMUMAB)	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