ADVANCED PHARMACY & RESPIRATORY CARE SOLUTIONS

Today's Date _____

INTERNAL MEDICINE REFERRAL FORM

Date Needed _____

26611 Cabot Road Suite B | Laguna Hills CA 92653
Ph 949-348-7900 | Toll Free 800-464-7736 | Fax 949-348-7920
NPI# 1922103142 NABP# 0547185
info@aps-rx.net APS-rx.net

☐ Phone Order
Ship to Patient:
☐ Home ☐ Work
Ship to:
☐ Physician Office
☐ Nurse / Training
☐ APS Pharmacy

Patient Name_____ Date of Birth_____ ☐ Male ☐ Female
Address_____ Apt #_____ City_____ State_____ Zip_____
Telephone_____ Cell_____ SSN_____ Email_____
Allergies_____ Comorbidities_____

Primary Insurance_____ ID#_____ Group #_____
Insured's Name_____ Employer_____
City_____ State_____ Phone_____

ICD-10 Diagnosis Code: ☐ E78.5 Unspecified Hyperlipidemia ☐ E78.0 Pure Hypercholesterolemia ☐ E08.9 Diabetes Mellitus without complications ☐ E08.8 Diabetes Mellitus with unspecified complications ☐ M81.0 Age-related Osteoporosis ☐ K58.0 IBS-D ☐ K59.0 Constipation ☐ _____
Patient currently on therapy? ☐ Yes ☐ No Type/medication(s) _____
Will patient stop taking the medication(s) before starting the new medication? ☐ Yes ☐ No
If yes, how long should patient wait before starting the new medication? _____
Current medications patient (including OTC) with dosage and direction (or fax medication) _____

Previously treated for this condition? ☐ Yes ☐ No Medication(s) failed _____
PPD (TB Test) ☐ Yes ☐ No Date_____

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

☐ **REPATHA®** ☐ Auto-Injector 140MG ☐ PFS 140MG
SIG: ☐ 140MG SC every 2 weeks ☐ 420MG SC once monthly
☐ Other: _____
QTY:_____ Refill:_____

☐ **PRAULENT®**
☐ Pen 150MG ☐ PFS 150MG ☐ Pen 75MG ☐ PFS 75MG
SIG: ☐ 75MG once every 2 weeks ☐ 150MG once every 2 weeks
QTY:_____ Refill:_____

☐ **OTEZLA®**
☐ Prescriber Provided 2 Week Starter Pack Sample
☐ 28-Day Starter Pack ☐ Maintenance
SIG: ☐ Take As Directed QTY: 55 Refill: 0
These directions can only be selected for the 28-Day Starter Pack
☐ Take 30 mg once daily QTY: 30 Refill:_____
☐ Take 30 mg twice daily QTY: 60 Refill:_____

☐ **DUEXIS®** 800 mg Ibuprofen/26.6 mg Famotidine
SIG: Take 1 tab orally 3x per day QTY:_____ Refill:_____

☐ **VIMOVO®** ☐ 375 mg/20 mg ☐ 500 mg/20 mg
SIG: 1 tablet 2x daily QTY:_____ Refill:_____

☐ **DIFICID®** 200mg TABLET
SIG: Take one tablet orally twice daily for 10 days with or without food QTY: 20 Refill:_____

☐ **VIBERZI®** ☐ 100mg ☐ 75mg QTY: 60 Refill:_____
SIG: Take 1 tablet by mouth twice daily with food.

☐ **XIFAXAN®** (RIFAXIMIN) ☐ 550mg TABLET
SIG: ☐ 1 550mg Tab PO TID x 14 Days QTY: 42 Refill:_____
☐ 1 550mg TAB PO BID QTY: 60 Refill:_____

☐ **LUCEMYRA™** 0.18mg TABLET
SIG: ☐ Take 3 tablets (0.54mg) by mouth every 5-6 hours during peak withdrawal symptoms for up to 14 days. QTY:_____ Refill:_____
☐ Other: _____
QTY:_____ Refill:_____

☐ **PROLIA®** 60mg PFS
SIG: Inject 60mg subcutaneously every 6 months
QTY: 1 Refill:_____

☐ **TYMLOS™** ☐ 1.56 mL Prefilled Multi-Dose Pen
SIG: Inject 80mcg subcutaneously once a day
QTY: 1 pen (30 day supply) Refill:_____

☐ **FORTEO®** 600MCG/2.4mL
SIG: Inject 20mcg SQ Daily as directed
QTY: ☐ 1 pen (4 wk supply) ☐ 3 pens (12 wk supply) Refill:_____

☐ **BD - 31G X 5MM PEN NEEDLES**
SIG: Use as directed with Forteo pen
QTY: 100 (1 Box) Refill:_____

☐ **PENNSAID® 2%**
SIG: 40 mg (2 pump actuations) on each painful knee, 2x daily.
QTY:_____ Refill:_____

BD ULTRA-FINE PEN NEEDLES
☐ Short 8mm 31G ☐ Mini 5mm 31G
SIG: _____ QTY: 1 Box Refill:_____

OTHER _____
SIG: _____ QTY:_____ Refill:_____

Prescriber's Name / Practice _____ Office Contact_____
Address_____ Suite#_____ City_____ State_____ Zip_____
Tel_____ Fax_____ Email_____
License#_____ NPI#_____ UPIN#_____ DEA#_____
Prescriber's Signature (signature required. NO STAMPS)_____ **Date**_____

Please fax completed referral form to
APS at **949-348-7920**
Visit us at **APS-rx.net** for online fillable forms.