echocare
SPECIALTY PHARMACY
"Your partner in patient care"

260 Broadway
Brooklyn, NY 11211
Phone: 718-782-0101
Fax: 718-782-2626
www.EchoDrugs.net

RHEUMATOLOGY REFERRAL FORM

Fax prescription to: 718-782-2626

Faxed prescriptions can only be accepted from prescribing practitioners

Date Needed By _____ Ship to: ☐ Patient ☐ Office ☐ Other: _____

PATIENT INFORMATION

Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ SS# _____ DOB _____

☐ Male ☐ Female Height_____ Weight _____ Age _____

Allergies _____ ☐ NKDA

INSURANCE INFORMATION

Please attach front and back of all insurance and prescription drug cards

PRESCRIBER INFORMATION

Name _____

NPI _____ State License# _____

Group/Hospital _____

Address _____

City, State, Zip _____

Main Phone _____ Fax _____

Contact Person _____ Phone _____

CLINICAL EVALUATION

DIAGNOSIS

☐ M06.9 Rheumatoid Arthritis
☐ M45.9 Ankylosing Spondylitis
☐ M32.10 Systemic Lupus Erythematosus
☐ L40.8 Psoriasis Moderate to Severe Plaque
☐ L40.50 Psoriatic Arthritis
☐ K50.90 Chron's Disease
☐ M81.0 Osteoporosis
☐ Other _____ DX code _____

Diagnosis Date _____

FORTEO/PROLIA

T-Score _____ Type _____ Date _____

Does patient have latex allergy? ☐ Yes ☐ No

PREVIOUS MEDICATIONS/THERAPIES

Medication	Duration of treatment/Reason for discontinuation
☐ Methotrexate	
☐	
☐	
☐	
☐	

LABS

Has TB test been performed?
☐ Yes (please attach results) ☐ No

Lab Date: TB Results:

FRACTURE HISTORY

Site	Date

PRESCRIPTION INFORMATION

MEDICATION	DOSAGE & DIRECTIONS	QUANTITY/DURATION	REFILLS
☐ **ACTEMRA (tocilizumab)**	☐ 162mg prefilled syringe - Inject subcutaneously: ☐ ONCE a week ☐ Every OTHER week ☐ _____ vial - Infuse _____ mg at _____	☐ 4-Weeks supply	
☐ **CIMZIA (certolizumab pegol)** ☐ 200mg x 2 prefilled syringe ☐ 200mg x 2 LYO powder	☐ Starter Kit: Inject 400mg subcutaneously at weeks 0, 2, and 4 ☐ Maintenance: Inject 400mg subcutaneously ONCE a MONTH ☐ Maintenance: Inject 200mg subcutaneously ONCE every 2 weeks	☐ 4-Weeks supply	
☐ **COSENTYX (secukinumab)** ☐ 150mg syringe ☐ 150mg pen	☐ Psoriatic arthritis induction (optional): 150mg subcutaneously at weeks 0, 1, 2, 3, and 4 ☐ Psoriatic arthritis maintenance: 150mg subcutaneously every 4 weeks ☐ Ankylosing spondylitis induction (optional): 150mg subcutaneously at weeks 0, 1, 2, 3, and 4 ☐ Psoriatic arthritis maintenance: 150mg subcutaneously every 4 weeks ☐ Other:	☐ Enter quantity _____	
☐ **ENBREL (etanercept)** ☐ 50mg prefilled syringe ☐ 50mg SureClick	☐ Inject 50mg subcutaneously ONCE a week ☐ Inject 25mg subcutaneously TWICE a week 72-96 hours apart	☐ 4-Weeks supply	
☐ **FORTEO (teriparatide rDNA origin)**	☐ Multi-dose prefilled pen - Inject 20mcg subcutaneously ONCE daily	☐ 4-Weeks supply	
☐ **HUMIRA (adalimumab)** ☐ 40mg/0.8ml pen ☐ 40mg/0.8ml prefilled syringe	☐ Inject 40mg subcutaneously every OTHER week ☐ Inject 40mg subcutaneously ONCE a week	☐ 4-Weeks supply	
☐ **ORENCIA (abatacept)** ☐ 125mg prefilled syringe ☐ 250mg vials	☐ Inject 125mg subcutaneously ONCE a week ☐ Infuse _____ mg at _____	☐ 4-Weeks supply	
☐ **OTEZLA (apremilast)** ☐ Starter pack ☐ 30mg tablets	☐ Starter pack: Initial titration over 5 days ☐ Maintenance: Take 1 tablet by mouth twice daily	☐ 1 Starter pack ☐ 60 tablets	
☐ **PROLIA (denosumab)**	☐ 60mg syringe: Inject 60mg subcutaneously once every 6 months	☐ 4-Weeks supply	
☐ **REMICADE (infliximab)**	☐ Infuse _____ mg at _____	☐ 4-Weeks supply	
☐ **RITUXAN (rituximab)**	☐ Infuse _____ mg at _____	☐ 4-Weeks supply	
☐ **SIMPONI (golimumab)** ☐ 50mg SmartJect ☐ ARIA ☐ PFS	☐ Inject 50mg subcutaneously ONCE a MONTH as directed ☐ Infuse _____ mg at weeks 0 and 4, then every 12 weeks	☐ 4-Weeks supply	
☐ **STELARA (ustekinumab)** ☐ 45mg prefilled syringe ☐ 90mg syringe	☐ Inject 45mg on day 0, then week 4, then every 12 weeks ☐ Inject 90mg subcutaneously ONCE a MONTH as directed	☐ 4-Weeks supply	
☐ **TYMLOS (abaloparatide)**	☐ Inject 80mcg subcutaneously ONCE daily	☐ Enter quantity _____	
☐ **XELJANZ (tofacitinib citrate)**	☐ 5mg tablet - Take 1 by mouth TWICE daily	☐ 60 tablets	
☐ **OTHER**			

By signing this form and utilizing our services, you are authorizing Echo Care Specialty Pharmacy and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature _____ ☐ DAW Date _____