PUBLIX PHARMACY

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Rheumatology Referral Form

Publix Specialty Pharmacy (#3212)

7616 Southland Blvd, Suite 112
Orlando, FL 32809
Phone: 855-797-8254
Fax: 863-413-5723

Patient Information [Attach copy of front and back of prescription insurance card(s)]

Patient's First Name: _____ Patient's Last Name: _____ Date of Birth: ___/___/_____ ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____

Primary Phone Number: (_____) _____ Alt. Phone Number: (_____) _____ Caregiver name: _____

Clinical Information [Attach copy of labs and office notes]

Diagnosis code: _____ Diagnosis: ☐ Rheumatoid Arthritis ☐ Ankylosing Spondylitis ☐ Other: _____

Treatment status: ☐ New to therapy, previously denied by insurance: ☐ No ☐ Yes, include copy of denial letter Enroll in copay card/ bridge program if available and eligible: ☐ No ☐ Yes

☐ Continuation of therapy, start date: ___/___/____ Is the patient on samples? ☐ No ☐ Yes Weight: _____ ☐ kg ☐ lb, Height: _____ ☐ cm ☐ in

TB test result (within 6 months): ☐ N/A ☐ Negative ☐ Positive, Date of TB test: ___/____/_____ Allergies: ☐ NKDA ☐ Other: _____

NSAIDs: ☐ Active, name and dose: _____ ☐ Contraindicated/failed, describe: _____

Conventional DMARDs (e.g. MTX, sulfasalazine): ☐ Active, name and dose: _____ ☐ Contraindicated/failed, describe: _____

Biologics (e.g. TNF blockers): ☐ Never tried ☐ Contraindicated/failed, describe: _____

MEDICATION	DOSE/STRENGTH	DIRECTIONS	DISPENSE QTY FOR	REFILLS
☐ Actemra (tocilizumab)	162 mg/0.9 mL prefilled syringe (PFS) Patient weight: _____	☐ <100kg: Inject 162 mg SC every 2 weeks ☐ ≥100kg: Inject 162 mg SC once a week	☐ 28 days ☐ 84 days	_____
☐ Cimzia (certolizumab pegol)	☐ Starter Kit: 200 mg/mL PFS	Initial Dose: Inject 400 mg (2 x 200 mg) SC on days 1, 15, and 29	3 doses	0
	☐ 200 mg/mL PFS ☐ 200 mg vial	Maintenance Dose: ☐ Inject 400 mg (2 x 200 mg) SC every 4 weeks ☐ Inject 200 mg SC every 2 weeks	☐ 28 days ☐ 84 days	_____
☐ Cosentyx (secukinumab)	☐ 150 mg/mL Sensoready pen ☐ 150 mg/mL PFS	☐ Initial Dose: Inject 150 mg SC once a week for 5 weeks (on days 1, 8, 15, 22, and 29)	56 days	0
		Maintenance Dose: ☐ Inject 150 mg SC every 4 weeks ☐ Inject 300 mg (2 x 150 mg) SC every 4 weeks	☐ 28 days ☐ 84 days	_____
☐ Enbrel (etanercept)	☐ 50 mg/mL SureClick pen ☐ 50 mg/mL PFS ☐ 25 mg/0.5 mL PFS	☐ Inject 50 mg SC ONCE a week ☐ Inject 25 mg SC TWICE a week (72-96 hours apart) ☐ Other: _____	☐ 28 days ☐ 84 days	_____
☐ Humira (adalimumab)	☐ 40 mg pen ☐ 40 mg PFS	☐ Inject 40 mg SC every 2 weeks ☐ Inject 40 mg SC once a week	☐ 28 days ☐ 84 days	_____
☐ Kevzara (sarilumab)	☐ 200 mg/1.14 mL PFS ☐ 150 mg/1.14 mL PFS	Inject SC every 2 weeks	☐ 28 days ☐ 84 days	_____
☐ Orencia (abatacept)	☐ 125 mg/mL ClickJect pen ☐ 125 mg/mL PFS	Inject 125 mg SC once a week	☐ 28 days ☐ 84 days	_____
	☐ 250 mg vial *(IV use only)* Patient weight: _____	☐ Infuse _____ mg IV over 30 min x 1 dose, then within 24 hours start SC dosing	1 dose	0
		☐ Infuse _____ mg IV over 30 min on days 1, 15, and 29 then every 4 weeks	28 days	_____
	Include: ☐ Sterile water for inj 10 mL vial ☐ Sodium chloride 0.9% inj 100 mL bag	Use 10 mL to reconstitute each 250 mg abatacept vial before dilution Dilute reconstituted abatacept to a final concentration of no more than 10 mg/mL	QS	_____
☐ Remicade (infliximab) ☐ Inflectra (infliximab-dyyb) ☐ Renflexis (infliximab-abda)	100 mg vial Patient weight: _____	☐ Initial Dose: Infuse _____ mg (____ mg/kg) IV over at least 2 hours on days 1, 15, and 43	3 doses	0
		☐ Maintenance Dose: Infuse _____ mg (____ mg/kg) IV over at least 2 hours every ____ weeks	1 dose	_____
	Include: ☐ Sterile water for inj 10 mL vial ☐ Sodium chloride 0.9% inj 250 mL bag	Use 10 mL to reconstitute each 100 mg infliximab vial before dilution Dilute reconstituted infliximab to a final concentration of 0.4 to 4 mg/mL	QS	_____
☐ Simponi Aria (golimumab)	50 mg vial	☐ Initial Dose: Infuse _____ mg (2mg/kg) IV over 30 min on days 1 and 29	2 doses	0
		☐ Maintenance Dose: Infuse _____ mg (2mg/kg) IV over 30 min every 8 weeks	56 days	_____
	Include: ☐ Sodium chloride 0.9% inj 100 mL bag	Dilute total volume of golimumab to a final volume of 100 mL	QS	_____
☐ Simponi (golimumab)	☐ 50 mg/0.5 mL SmartJect pen ☐ 50 mg/0.5 mL PFS	Inject 50 mg SC every 4 weeks	☐ 28 days ☐ 84 days	_____
☐ Xeljanz (tofacitinib)	☐ 5 mg tablet	Take 1 tab PO BID with or without food	☐ 30 days ☐ 90 days	_____
	☐ 11 mg XR tablet	Take 1 tab PO once daily with or without food		

Prescriber Information [Ship to prescriber: ☐ Never ☐ Always ☐ First fill only, appointment date: ___/___/_____] Use Cover My Meds: ☐ No ☐ Yes

Name: _____ DEA# _____ NPI # _____

Address: _____ City: _____ State: _____ Zip: _____

Office Phone Number: (_____) _____ Fax Number: (_____) _____ Office Contact: _____

I authorize Publix Pharmacy representatives to act on behalf of the prescriber to initiate and complete the insurance prior authorization process.

Prescriber's signature: _____
(stamps not accepted)

☐ Substitution allowed Date

☐ Dispense as written/ Do not substitute Date

For states requiring hand written expressions to prevent substitution, write here: