SAGE SPECIALTY PHARMACY

**Faxed prescriptions will only be accepted from an authorized prescriber.** Prescribers are reminded patients may choose any pharmacy of their choice.

# Sage Specialty Pharmacy Rheumatology Referral Form

WWW.SAGE-SPECIALTYPHARMACY.COM

| **Patient Information:** Please provide a copy of the patient's insurance card or information | | | | |
|---|---|---|---|---|
| Patient Name: | DOB: | Gender: | Ht: | Wt: |
| Address: | City: | State: | Zip Code: | Phone: |
| Insurance: | Subscriber's Name: | | ID#: | Group#: |
| Allergies: □NKDA □ List Allergies: | | | | |

**Clinical Information:** please provide recent clinical notes, labs, and tests to expedite the prior authorization process

ICD-10 and Diagnosis:_____

Previously failed therapies:

□ Corticosteroid □ COX-2 □ Cyclosporine □ Hydroxychloroquine
□ JAK Inhibitor □ Leflunomide □ Methotrexate □ NSAID
□ Other DMARD: _____ □ Sulfasalazine □ TNF Inhibitor
□ Other Biologic:_____

Dates used and reason for failure:_____
_____
_____

Is the patient currently receiving other immunosuppressive therapy?
□ Yes:_____
□ No

Other Notes:_____

Quantiferon TB Status: □ Positive □ Negative □ Pending

**Prescription Information**

| Medication | Strength | Sig | Quantity | Refills |
|---|---|---|---|---|
| □ Cimzia | □ Starter Kit<br>□ 200mg/mL PFS | □ Initial: Inject 400mg SC at weeks 0, 2, and 4.<br>Maintenance:<br>□ Inject 200mg every 2 weeks<br>□ Inject 400mg every 4 weeks | □ 28 Day Supply | □ 0<br>□ ____ |
| □ Duexis | □ 800mg/26.6mg Tablets | □ Take 1 tablet by mouth 3 times daily<br>□ Other: | □ 90 Tabs<br>□ | □ |
| □ Enbrel | □ 50mg/mL SureClick Autoinjector<br>□ 50mg/mL Mini Cartridge<br>□ 50mg/mL PFS<br>□ | □ Inject 50mg SC once weekly<br>□ Other: | □ 28 Day Supply | □ |
| □ Forteo<br>□ Pen Needles | □ 250mcg/2.4mL Pen | □ Inject 20 mcg SC every day<br>□ Use to inject Forteo every day | □ 28 Day Supply<br>□ 1 Box | □ |
| □ Humira | □ 40mg/0.4mL Citrate Free Pen<br>□ 40mg/0.4mL Citrate Free PFS | □ Inject 40mg SC every other week<br>□ Inject 40mg SC every week<br>□ Other: | □ 28 Day Supply | □ |
| □ Kevzara | □ 200mg/1.14mL Pen<br>□ 200mg/1.14mL PFS<br>□ Other: | □ Inject 200mg SC every 2 weeks<br>□ Other: | □ 28 Day Supply | □ |
| □ Orencia | □ 125mg/mL ClickJet<br>□ 125ng/mL PFS | □ Inject 125mg SC every week | □ 28 Day Supply | □ |
| □ Otezla | □ Starter Pack<br>□ 30mg Tablets | □ Starter Pack: Take as directed per package instructions<br>□ Take 1 tablet by mouth twice daily | □ 1 Month Supply | □ |
| □ Otrexup | □ | □ Inject 1 pen SC once weekly<br>□ Other: | □ 28 Day Supply | □ |
| □ Pennsaid | □ 2% Solution | □ Apply 2 pumps to each painful knee twice daily<br>□ Other: | □ 1 Bottle | □ |
| □ Prolia | □ 60mg/mL PFS | □ Inject 1 syringe SC once every 6 months by a healthcare provider. | □ 1 Syringe | □ |
| □ Rasuvo | □ | □ Inject 1 pen SC once weekly<br>□ | □ 28 Day Supply | □ |
| □ Rinvoq | □ 15mg ER Tablets | □ Take 1 tablet by mouth every day | □ 30 Tabs | □ |
| □ Rayos | □ 1mg DR Tablets<br>□ 2mg DR Tablets<br>□ 5mg DR Tablets | □ Take _____ tablets by mouth _____ times daily | □ 1 Month Supply | □ |
| □ Simponi | □ 50mg/0.5mL SmartJect<br>□ 50mg/0.5mL PFS<br>□ | □ Inject 50mg SC once a month<br>□ Other: | □ 1 Month Supply | □ |
| □ Stelara | □ 45mg/0.5mL PFS<br>□ 90mg/mL PFS | □ Initial: Inject 1 syringe SC at 0 and 4 weeks<br>□ Maintenance: Inject 1 syringe SC every 12 weeks | □ 1 Box | □ |
| □ Vimovo | □ 375mg/20mg Tablets<br>□ 500mg/20mg Tablets | □ Take 1 tablet by mouth twice daily<br>□ Other: | □ 60 Tablets | □ |
| □ Xeljanz | □ 5mg Tablets | □ Take 1 tablet by mouth twice daily | □ 60 Tabs | □ |
| □ Xeljanz XR | □ 11mg ER Tablets | □ Take 1 Tablet by mouth every day | □ 30 Tab | □ |

**Prescriber Information**

| Name: | Phone: | Office Contact Name: | |
|---|---|---|---|
| Address: | City: | State: | Zip: |
| NPI: DEA: | Fax and/or Email: | | |
| Prescriber Signature: | Date: | □ DO NOT SUBSTITUTE | |

Sage Specialty Pharmacy – Phone: 414-861-7243 Fax: 414-906-0187 Address: 4001 N Oakland Ave Shorewood, WI 53211

I authorize Sage Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process. IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.