COTTRILL'S SP

1-844-268-8745

RHEUMATOID ARTHRITIS & ANKYLOSING SPONDYLITIS PATIENT REFERRAL & Rx FORM

PLEASE INCLUDE ALL MEDICAL RECORDS AND LABS PLEASE FAX TO 1-716-508-8482

PATIENT INFORMATION

Last Name ____________ First Name ____________ DOB ____________

Address ____________ City ____________ State ____________ Zip ____________

Gender: ☐ Male ☐ Female Height ____________ Weight ____________ Social Security # ____________

Home Phone ____________ Cell ____________ Email Address ____________

Allergies ____________ Emergency Contact Name ____________ Phone ____________

INSURANCE INFORMATION

Please provide a current copy of insurance card(s) or complete the following information

Primary Insurance ____________ Policy # ____________ Group # ____________ Phone ____________

Policy Holder's Name ____________ DOB ____________

Secondary Insurance ____________ Policy # ____________ Group # ____________ Phone ____________

Policy Holder's Name ____________ DOB ____________

CLINICAL INFORMATION

Primary Diagnosis: ____________ Diagnosis Code: ____________

Secondary Diagnosis: ____________ Diagnosis Code: ____________

Negative Tb Test: ☐ Yes ☐ No Tb Test Date: ____________

Latex Allergy: ☐ Yes ☐ No

Previous Therapy: ____________

Previous Therapy Dates: ____________

PRESCRIPTIONS

Medication	Strength	Quantity	Directions	Refills
☐ **Actemra® (Tocilizumab)**	☐ 162 mg Prefilled Syringes	2	☐ Inject 162 mg (1 syringe) under the skin every other week	
		4	☐ Inject 162 mg (1 syringe) under the skin every week	___
☐ **Cimzia® (Certolizumab)**	☐ 200 mg Starter Kit	6	**Titration Dose:** Inject 400 mg (2 syringes) under the skin on days 0, 14, and 28	0
	☐ 200 mg Prefilled Syringes	2	☐ **Maintenance Dose**: Inject 200 mg (1 syringe) under the skin every 2 weeks ☐ **Maintenance Dose**: Inject 400 mg (2 syringes) under the skin every 4 weeks	___
☐ **Enbrel® (Etanercept)**	☐ 25 mg Prefilled Syringes ☐ 50 mg Prefilled Syringes ☐ 50 mg SureClick® Autoinjector	4	☐ **Maintenance Dose**: Inject 25 mg (1 syringe) under the skin every week ☐ **Maintenance Dose**: Inject 50 mg (1 syringe) under the skin every week	
		8	☐ **Maintenance Dose:** Inject 25 mg (1 syringe) under the skin twice a week	___
☐ **Humira® (Adalimumab)**	☐ 20 mg Prefilled Syringes ☐ 40 mg Pens ☐ 40 mg Prefilled Syringes	2	☐ **Maintenance Dose**: Inject 10 mg (½ syringe) every other week ☐ **Maintenance Dose**: Inject 20 mg (1 syringe) every other week ☐ **Maintenance Dose**: Inject 40 mg (1 pen/syringe) under the skin every other week	
		4	☐ **Maintenance Dose**: Inject 40 mg (1 pen/syringe) under the skin every week	___
☐ **Simponi® (Golimumab)**	☐ 50 mg SmartJect® Autoinjector ☐ 50 mg Prefilled Syringes	1	☐ **Maintenance Dose**: Inject 50 mg (1 syringe) under the skin every 4 weeks	___
☐ **Xeljanz® (Tofacitinib)**	5 mg Tablets	60	☐ Take one tablet by mouth twice a day	
		30	☐ **(Renal Impairment)**: Take one tablet by mouth once a day	___
☐ **Other:** ____________	____________	____	**Directions**: ____________	___

EDUCATION AND DELIVERY INSTRUCTIONS

Education: ☐ Cottrill's Specialty Pharmacy to coordinate injection ☐ training Physician's office to provide injection training

Deliver to: ☐ Patient's home ☐ Physician's Office ☐ 1st dose to physician's office - remaining to patient home

PHYSICIAN INFORMATION

Physician Name ____________ NPI# ____________

License # ____________ State ____________ DEA# ____________

Address ____________ City ____________ State ____________ Zip ____________

Phone ____________ Fax ____________ Office Contact ____________

____________ ____________ ____________

Product Selection Permitted **Dispense as Written** **Date**

Cottrill's will verify insurance benefits, initiate PA's and notify patient prior to admission of any out of pocket expenses or co-payments