COOKEVILLE REGIONAL MEDICAL CENTER
It's the Way WeCARE

Rheumatology Referral Form

FOR INFORMATION
Specialty Services: (931) 783-5551
Fax referral #: (931) 783-5533
Outpatient Pharmacy
931-783-2552 phone
931-783-2553 fax

Referral Info

PATIENT INFORMATION

Patients Name:		SSN#:		DOB:	
Address:		City:	State:	Zip:	
Home Phone:	Cell Phone:	Height:	Weight:	Gender: Male	Female
Email Address:		Diagnosis Code:			

INSURANCE INFORMATION (or attach copy of your cards)

Primary Insurance Co:	Phone:	Policy#:	Group#:
Secondary Insurance Co:	Phone:	Policy#:	Group#:

PRESCRIPTION INFORMATION

To prevent generic substitution, Prescriber to handwrite "Brand Medically Necessary" and sign:

❑ ACTEMRA®	❑ INDUCTION	❑ MAINTENANCE
❑ COSENTYX®	❑ INDUCTION	❑ BRIDGE* ❑ MAINTENANCE
❑ CIMZIA®	❑ INDUCTION	❑ MAINTENANCE
❑ ENBREL®	❑ INDUCTION	❑ MAINTENANCE
❑ KEVZARA®	❑ INDUCTION	❑ MAINTENANCE
❑ HUMIRA® CITRATE-FREE	❑ STARTER PACK	❑ MAINTENANCE
❑ HUMIRA®	❑ STARTER PACK	❑ MAINTENANCE
❑ OTEZLA®	❑ TITRATION PACK	❑ BRIDGE ❑ MAINTENANCE
❑ TALTZ®	❑ INDUCTION	❑ MAINTENANCE
❑ SIMPONI®	❑ INDUCTION	❑ MAINTENANCE
❑ XELJANZ®	❑ INDUCTION	❑ MAINTENANCE
❑ OLUMIANT®	❑ INDUCTION	❑ MAINTENANCE

*Covered Until You're Covered Program

INDUCTION STARTER	MAINTENANCE
STRENGTH:	**STRENGTH:**
SIG/DIRECTIONS	**SIG/DIRECTIONS**
❑ AUTOINJECTOR ❑ PEN ❑ PREFILLED SYRINGE ❑ VIAL	❑ AUTOINJECTOR ❑ PEN ❑ PREFILLED SYRINGE ❑ VIAL
QUANTITY: **REFILLS:**	**QUANTITY:** **REFILLS:**

Primary Diagnosis
❑ Rheumatoid Arthritis ❑ Psoriatic Arthritis
❑ Other: _____
❑ Osteoporosis ❑ Forteo ❑ Prolia ❑ Other _____

Prior Treatment
❑ Methotrexate ❑ Duration _____
❑ Cyclosporine ❑ Duration _____
❑ Sulfasalazine ❑ Duration _____
❑ Other ❑ Duration _____

OTB/PPD Test Negative? ❑ Yes ❑ No Date of Test: _____

Medical Justification for Prescribing Biologic Therapy (or attach history)
No reponse to previous treatment
(list): _____
Contraindications
(list): _____
Side effects, lab abnormalities, toxicity issues
(list): _____

❑OTHER
STRENGTH:
SIG/DIRECTIONS
QUANTITY: **REFILLS:**

PHYSICIAN INFORMATION

Injection Training: ☐ Office to Instruct ☐ SP to Arrange Teaching

Prescriber Name:	Phone:	Fax:
Office Contact/Faxed By:	Email:	
NPI#:	TAX ID#:	Ship To: ❑ Patient ❑ MD Office 1st Order Only ❑ MD Office All Orders
Prescriber Signature	Date:	

❑ Dispense as written

Your signature authorizes the pharmacy to act on your behalf to obtain prior authorization for the prescribed medications. We will also pursue available copay and financial assistance on behalf of your patients.

This prescription is valid only if transmitted by facsimile machine by a licensed prescriber.