ACS Advanced Care Scripts

RACare™ Referral Form

Phone: 877-985-MEDSFax: 866-679-7131

(6337)

Complete Patient Demographic Information in Section Below OR Attach Face Sheet from Patient Chart					
First Name	*Middle Initial*	*Last Name*	*Date of Birth*	*Gender* ☐ M ☐ F	*Social Security Number*
Street Address:					
City	*State*	*Zip Code*	*Home Phone*	*Work Phone*	*Cell Phone*

Complete Patient Insurance Information in Section Below OR Attach Copies of Patient Insurance Card					
Insurance Carrier Name - Primary	*Name of Insured*	*Relationship*	*ID#*	*Group #*	*Insurance Phone*
Rx Carrier Name - Secondary	*Rx ID#*	*Rx Group #*	*Rx Phone #*		

Complete Drug Therapy Information in Section Below OR Attach Completed Prescription

Drug Name	Form/Strength/Directions for Use	Qty	Refills
Cimzia	☐ **Starting dose:** 400mg SC at 0, 2, 4 weeks then ☐ **On going** 200mg SC every other week ☐ 400 mg SQ every 4 weeks ☐ 200mg lyophilized vial ☐ 200mg Pre-filled syringe		
Enbrel	☐ 50 mg SQ weekly ☐ PFS or ☐ Sureclick ☐ 25 mg SQ BIW ☐ Other: _____ ☐ 1 year		
Humira	**Starting dose:** ☐ 80mg SQ x one initial dose then ☐ 40mg SQ every other week starting one week after initial dose. Dispense in starter package for initial dosing. **Maintenance dosing:** ☐ 40 mg SQ every other week ☐ Pen or ☐ PFS ☐ 40 mg SQ once a week ☐ Pen or ☐ PFS ☐ Other: ____		
Otezla	☐ Therapy Initiation Titration Pack-Take as Directed ☐ 30mg twice a day ☐ 30mg once a day (Patients with Severe Renal Impairment)		
Simponi	☐ 50 mg/0.5 ml SC once a month ☐ Pre-filled SmartJet™ ☐ Pre-filled syringe single dose		
Stelara Ship to ☐ MDO ☐ Patient	**Initial Dosing:** ☐ 45mg PFS SQ x1 followed by 45mg PFS SQ in 4 weeks (For patients weighting ≤ 100kg) ☐ 90 mg PFS SQ x1 followed by 90mg PFS SQ in 4 weeks (For patients weighting > 100kg) **Ongoing Dosing:** ☐ 45mg PFS SQ every 12 weeks ☐ 90mg PFS SQ every 12 weeks		
Remicade	☐ _____ mg/kg IV at 0, 2, 6 Weeks → Maintenance Dose: _____ mg/kg IV Q 8 Weeks ☐ _____ mg/kg IV Q 8 Weeks ☐ Other: ___		
XELJANZ	☐ 5mg PO Twice a day		

Information Needed to Obtain Prior Authorizations	
Primary Diagnosis: ☐ Rheumatoid Arthritis, ICD10:___ ☐Psoriatic Arthritis. ICD-10 ____ ☐Other:	*Weight:*
Allergies:	
Failed Therapies: ☐ Methotrexate ☐ Humira ☐other	
Please provide current List	

Complete Prescriber Information in Section Below NOT Included on Attached Prescription					
MD First Name	*MD Last Name*	*DEA #*	*UPIN*	*State License #*	*NPI*
Office Address:					
City:		*State:*	*Zip:*		
Office Phone:		*Office Fax:*			
Office Contact Name:		*Office E-mail:*			

SIGNATURE OF LICENSED PRESCRIBER IS REQUIRED TO VALIDATE PRESCRIPTIONS

☐ *I authorize Advanced Care Scripts to initiate a Prior Authorization on my behalf* *TLC2/3/16*

Dr: ***Substitution Permitted***	**Dr:** ***No Substitution Permitted***	**Date:**