Rheumatology Referral Form

BIOMED Pharmaceuticals **Phone: (817) 923-4495** **Toll Free: (866) 923-4495** **Intake Fax: (866) 923-4492**

Corporate Office	Desoto	Houston	Tyler	San Antonio
1512 8th Ave. Suite 100	2727 Bolton Boone Dr. Ste 110	1919 N. Loop West, Ste 180	837 S. Fleishel	211 North San Saba, Suite 205
Fort Worth, TX 76104	Desoto, TX 75115	Houston, TX 77008	Tyler, TX 75701	San Antonio, TX 78207

Name: ____________________ Date of Birth: ____________________

Address:____________________ City: ____________________State: ________ Zip:__________

Home Phone: ____________________Work Phone: ____________________Cell Phone: ____________________Male ____Female ____

Primary Insurance:	Secondary Insurance:
Phone #:	Phone#:
Subscriber: DOB:	Subscriber: DOB:
ID#: Policy/Group#:	ID#: Policy/Group#:

Prescription Drug Card ____________________ Number ____________________

Statement of Medical Necessity **Diagnosis:**

____ Psoriatic Arthritis (696.0)

____ Ankylosing Spondylitis (720.0)

____ Fibromyalgia (729.1)

—— Rheumatoid Arthritis

____ Other (_____) ICD9 Code ________________________________

Weight______(lbs) _______(kg)

Allergies:__________________________________

Medications:____NO ____YES (please explain)

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Prescription: good for one year unless otherwise specified under special instructions.

___ IVIG _______Dosage _______ Frequency _________Flush 5ml NS or D5 as indicated by brand before and after infusion

_________________________ Brand desired, if available.

___ Enbrel 25mg and Sterile Water for injection and related supplies (given SQ) __________ Frequency

___ Enbrel 50mg pre-filled syringe (given SQ) _________ Frequency

___ Anevive _______ Dosage _____________ Frequency ______Sterile Water for injection (given IM at AAIC infusion center)

___ Humira Dosage 40mg Frequency _______(given SQ)

Injection Training at Physician's Office _____ TB test

Repeat Remicade:___________ wks

Special Instructions____

Physician Certification: I certify the above therapy is medically necessary for 1 year, and the information is accurate to the best of my knowledge.

Signature:____ Date________________________

Print Name:______________________________ DEA#____________________________ NPI#______________________________

Address:______________________________________ City:______________________________ St______ Zip_____________

Please send front and back copy of all insurance cards with referral.

1-16-08