Galaxy SPECIALTY PHARMACY
(Christus SantaRosa Hospital, Tower # 1)

Faxed prescriptions will only be accepted from a prescribing practitioner.
Patients must bring an original prescription to the pharmacy.

Rheumatoid Arthritis Prescription Referral

2829 Babcock Road, Suite # 120 • San Antonio- 78229, TX • Ph : 210.617.4311 • Fax: 210.617.4312
www.GalaxySpecialtyPharmacy.com

Date Medication Needed: _____ **Ship To:** ◯ Patient's Home ◯ Prescriber's Office ◯ Pick-up _____ Injection training by pharmacy?

1: Patient Information

Patient Name: _____ **Birthdate:** _____ **Sex:** Male Female **Height:** _____ **Weight:** _____ lbs. kg.

Soc. Sec. #: _____ **Preferred Phone:** _____ **Known Allergies:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Alternate Caregiver Name: _____ **Preferred Phone:** _____

Insurance Information: Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)

2: Prescriber Information

_____ _____ **DEA#:** _____ **NPI#:** _____ **Tax ID#:** _____

Address: _____ **Phone:** (_____) _____ - _____ **Fax:** (_____) _____ - _____

City: _____ **State:** _____ **Zip:** _____ **Key Contact:** _____ **Phone:** (_____) _____ - _____

3: Diagnosis/Clinical Information | *Please FAX recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization*

Diagnosis: **Other:** _____

Prior failed medications (medication and duration of treatment/reason for d/c):

_____

_____

Is patient currently on RA therapy? Yes No

Medications: _____

TB/PPD test given? Yes No

BMD/T-score: _____ **Date:** _____

Does patient have a latex allergy? Yes No

Is Patient at risk for osteoporotic fracture as evident by any of the following?

History of osteoporotic fracture Site: _____ Date: _____

Patient has tried and failed an oral bisphosphonate

Patient has documented contraindication/is intolerant to oral bisphosphonate therapy (please submit a copy of DEXA w/prescription)

4: Prescription Information | *Xeljanz NOT to be used in combination with biologic DMARD's*

Medication	Dose/Strength	Sig	Qty.	Refills
Actemra®	162mg/0.9ml PFS	Inject 1 syringe SC every week Inject 1 syringe SC every other week	4-week supply	
Cimzia® Initial Dose	200mg Starter Kit (contains 6, 200mg PFS)	Inject 400mg SC once, then repeat at weeks 2 and 4	4-week supply	No refills
Cimzia® Maintenance Treatment	2 x 200mg Prefilled Syringe	200mg SC ONCE every TWO weeks 400mg SC ONCE every FOUR weeks	4-week supply	
Enbrel®	50mg/ml SureClick™ Autoinjector 50mg/ml Prefilled Syringe 25mg/0.5ml Prefilled Syringe	Inject 50mg SC ONCE a week Inject 25mg TWICE a week, 72 to 96 hours apart **Other:**	4-week supply	
Forteo®	600mcg/2.4ml PFS	Inject 20mcg SC, as directed, once daily	4-week supply	
Pen Needles	31 gauge 6mm		28 needles	
Humira® Injection training from My Humira ***(patient must sign below)***	40mg/0.8ml Pen 40mg/0.8ml Prefilled Syringe	Inject 40mg SC every OTHER week Inject 40mg SC ONCE a week	4-week supply	
Orencia®	125mg/ml Prefilled Syringe (4 syringes)	Inject 125mg SC ONCE weekly		
Otezla®	*Please use Otezla-specific referral form available at* ***avella.com/forms***			
Prolia®	60mg Prefilled Syringe	Inject 60mg SC ONCE every 6 months		
Simponi®	50mg/0.5ml Prefilled Syringe 50mg/0.5ml Autoinjector	Inject 50mg ONCE a month	4-week supply	
Xeljanz®	5mg	Take 5mg by mouth TWICE daily		

Patient Support Programs: Please sign and date below to enroll in the pharmaceutical company assisted patient support program

Patient Signature: Date:

Prescriber Signature: Prescriber, please sign and date below

Dispense as written Date Substitution Permissable Date

Pursuant to VA/OH/MO/VT law, only 1 medication is permitted per order form. Please use a new form for additional items.

# of Prescriptions: _____