BlueCross BlueShield of Montana
Live Smart. Live Healthy.

PRIME THERAPEUTICS SPECIALTY PHARMACY

SIGN AND FAX THIS FORM TO 877.828.3939
If you have questions, please call 877.627.MEDS (6337)

RHEUMATOID ARTHRITIS/PSORIATIC ARTHRITIS, AS, JIA REFERRAL FORM

PATIENT/PRESCRIBER

PATIENT INFORMATION		PRESCRIBER INFORMATION	
First name:	MI:	Title: First name:	
Last name:		Last name:	State license #:
Patient DOB:	Sex:	Provider NPI #:	DEA #:
Address:		Office name:	Office contact:
City/State/Zip:		Address:	
Primary phone:		City/State/Zip:	
Alternate phone:		Phone:	Fax:

PLAN

FAX A COPY OF THE FRONT AND BACK OF ALL INSURANCE CARDS

Primary insurance:	Policy ID #:		Group #:
Policyholder name:	Policyholder DOB:	PCN:	BIN:

CLINICAL

Primary diagnosis:	Height:	Weight:
ICD 9:	Allergies:	
Other health conditions:	Current medications:	

Joints affected: ___________ Number of tender joints: ___________ Number of swollen joints: __________% BSA affected: ___________

ESR & date: ___________________ CRP & date: ____________________________ TB results & date: ________________________________

PRESCRIPTION INFORMATION

Date needed: ☐ New prescription ☐ Refill prescription ☐ New to therapy ☐ Restarting therapy

Deliver to: ☐ Patient's home ☐ Prescriber's facility ☐ Physician provides injection training Date: ___________________

MEDICATION	FORM AND STRENGTH	QTY	DOSE, DIRECTIONS AND FREQUENCY
Actemra (tocilizumab)	☐ 80 mg/4 ml vial ☐ 200 mg/10 ml vial ☐ 400 mg/20 ml vial		
Cimzia (certolizumab pegol)	☐ 2 x 200 mg syringe kit ☐ 2 x 200 mg vial kit ☐ 6 x 200 mg syringe starter kit		
Enbrel (etanercept)	☐ 25 mg syringe x 4 ☐ 25 mg vial x 4 ☐ 50 mg syringe x 4 ☐ 50 mg SureClick x 4		
Humira (adalimumab)	☐ 20 mg syringe x 2 ☐ 40 mg syringe x 2 ☐ 40 mg pen x 2		
Kineret (anakinra)	☐ 100 mg syringe x 28		
Orencia (abatacept)	☐ 250 mg vial ☐ 125 mg syringe x 4		
Remicade (infliximab)	☐ 100mg vial		
Rituxan (rituximab)	☐ 100 mg vial ☐ 500 mg vial		
Simponi (golimumab)	☐ 50 mg syringe ☐ 50 mg SmartJect		
Methotrexate	☐ 2.5 mg tablet. Can only be ordered as combined therapy with one of the above drugs.		

☐ **Other**

☐ Check here if you would like associated supplies dispensed along with injectable medications. State restrictions apply. Separate prescriptions are required in some jurisdictions. **REFILLS: NR 1 2 3 4 5____**

PRESCRIBER SIGNATURE: PRESCRIBER SIGNATURE IS REQUIRED TO VALIDATE PRESCRIPTIONS.

☐ **Dispense as written/Do not substitute** **Date** ☐ **Substitution permitted/Brand exchange permitted** **Date**

For states requiring hand written expressions of product selection use this area (e.g. medically necessary, may not substitute, dispense as written, etc.).

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