



RA Therapy Referral

Fax to 866-406-4215

Customer Service: 866-406-4209

MEDICA®

Patient Information Please type or print clearly.	Name		
	Address		
	City	State	ZIP Code
	DOB		
	Home Phone w/area code		Work Phone w/area code
Insurance Information <input type="checkbox"/> Major Medical <input type="checkbox"/> Rx Benefit Please attach a copy of card(s) if possible.	Primary Insurer		
	Cardholder		
	DOB		
	Cardholder ID #		Group #
	RxCARD ID #	RxBin #	RxGroup #
	Phone w/area code		Fax w/area code
Medical Assessment	Diagnosis <input type="checkbox"/> 714.0 Rheumatoid Arthritis <input type="checkbox"/> 714.30 Juvenile Rheumatoid Arthritis <input type="checkbox"/> _____		
	Allergies		
Prescription To be valid, prescription must be faxed from a prescriber's office. Facsimile not valid for C-II prescriptions.	Enbrel® <input type="checkbox"/> Enbrel 25 mg Kit (4 vials) <input type="checkbox"/> Enbrel 50 mg Prefilled Kit (4 syringes) <input type="checkbox"/> Enbrel 50 mg SureClick™ Autoinjector Kit (4 syringes) Adult Directions: <input type="checkbox"/> 25 mg SC injection twice a week <input type="checkbox"/> Two 25 mg (50 mg) SC injections once a week <input type="checkbox"/> 50 mg SC injection once a week <input type="checkbox"/> _____ Pediatric Directions: (4 to 17 years) <input type="checkbox"/> 31 kg (68 lbs) or more: 0.8 mg/kg/wk given as two injections <input type="checkbox"/> Less than 31 kg (68 lbs): 0.8 mg/kg/wk given as one injection Weight (kg) _____ Days Supply _____ Refills X _____	Kineret® <input type="checkbox"/> Kineret 100 mg Prefilled Kit (28 syringes) Directions: <input type="checkbox"/> 100 mg SC injection daily <input type="checkbox"/> _____ Days Supply _____ Refills X _____	Humira® <input type="checkbox"/> Humira 40 mg Prefilled Kit (2 syringes) <input type="checkbox"/> Humira Pen 40 mg Prefilled Kit (2 pens) Directions: <input type="checkbox"/> 40 mg SC injection once a week <input type="checkbox"/> 40 mg SC injection every other week <input type="checkbox"/> _____ Days Supply _____ Refills X _____
	Prescriber Certification I certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge. Prescriber Signature Required _____ Date _____ Print Prescriber Name _____ Form Faxed By _____ UPIN _____ Address _____ DEA # _____ City _____ State _____ ZIP Code _____ Phone w/area code _____ Fax w/area code _____		

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