

REFERRAL FORM

FAX Referral Form To

803-461-0394
Toll Free Fax
866-437-6728



Contact Number

803-461-0393
Toll Free Number
866-437-6717

630 Kilbourne Rd., Columbia, SC 29205

Long's Pharmacists: Kimberly Taylor, RPh Christi Epps, PharmD Jody Yates, RPh

Date: _____ Date Needed By: _____ Ship Medication To: Patient MD Office Other

Physician Information

Physician/Office Name:		Phone:
Address:		Fax:
DEA Number:	State License Number:	Contact:

Patient - Information

PLEASE: Fax front and back copy of the patient's insurance card(s)

Patient Name:	Date of Birth:	Pt. Phone Number:	
Patient Shipping Address:	City:	State:	Zip:
Pt. Social Security Number	Name of Insured:		
Insurance:	ID Number:	Group Number:	

Clinical Information

Failed Therapy:	Dose/Strength	Duration	Dose/Strength	Duration
<input type="checkbox"/> NSAID			<input type="checkbox"/> Arava	
<input type="checkbox"/> COX-2			<input type="checkbox"/> penicillamine	
<input type="checkbox"/> Corticosteroids			<input type="checkbox"/> Cyclosporine	
<input type="checkbox"/> Methotrexate			<input type="checkbox"/> Imuran	
<input type="checkbox"/> Sulfasalazine			<input type="checkbox"/> Cytokan	
<input type="checkbox"/> Gold			<input type="checkbox"/> TNF	
<input type="checkbox"/> Plaquenil			<input type="checkbox"/> Other	

Diagnosis:

- 714.0 Rheumatoid Arthritis
 714.31 JRA
 Other: _____

Allergies: _____
 TB/PPD Test Given: _____
 Hepatitis Test Given/Results: _____

Follow up with MD in: 3 month follow up 6 month follow up 9 month follow up 12 month follow up

Treatment	Dose/Strength	Dose/Frequency	Quantity	Refills
<input type="checkbox"/> Enbrel	SureClick 50mg/ml	#4 ; 50mg SC once weekly	_____	_____
<input type="checkbox"/> Enbrel	50mg/mL Prefilled Syringe	#4 ; 50mg SC once weekly	_____	_____
<input type="checkbox"/> Enbrel	25mg/vial	#8 vials; 25 mg SC twice weekly	_____	_____
<input type="checkbox"/> Humira	Humira Pen 40mg/ml	#2; 40mg EOW	_____	_____
<input type="checkbox"/> Humira	Humira Pen 40mg/ml	#4; 40mg Every Week	_____	_____
<input type="checkbox"/> Humira	40mg/ml Prefilled Syringe	#2 ; 40mg EOW	_____	_____
<input type="checkbox"/> Humira	40mg/ml Prefilled Syringe	#2 ; 40mg Every Week	_____	_____
<input type="checkbox"/> Other			_____	_____

Notes: _____

Dispense as Written _____ Date _____ Substitution Permitted _____ Date _____