Patient Referral Form

Please attach Patient Insurance Sheet and EMR FAX: 866-549-7219 ● TOLL-FREE: 866-547-0644



TO ePRESCRIBE: Search for Rx Crossroads, LLC in ZIP CODE 40218

NCPDP#: 1827104

□ EMR attached

Patient Information			
*Full Name:	*Gender: M □ F □	*DOB:	
Parent/Guardian Name:	Parent/Guardian Phone:		
*Address:			
*City:	*State:	*Zip:	
rimary Phone: Alternate Phone:			
Patient Medical Information			
Primary Diagnosis/ICD-10: ☐ Rheumatoid Arthritis ☐ NOMID / CAPS ☐ Other:			
Secondary Diagnosis/ICD-10:			
Primary Diagnosis/ICD-9 (please list):	Secondary Diagnosis/ICD-9 (please list):		
Physician Information			
*Prescriber Name:	Practice Name:		
*Phone:	*Fax:		
Email:	Office Contact Name:	Office Contact Name:	
*Primary Address:	*City:	*State: *Zip:	
Secondary Address:	City:	State: Zip:	
Specialty: *Tax ID#:	*NPI #:	*DEA #:	
Prescription Drug Information and Treatment Settings			
Is patient currently on KINERET [®] therapy? : Y □ N □	KINERET $^{\circ}$ on hand: Y \square N \square		
Deliver to: ☐ Patient's home ☐ Physician's office	Initial Treatment Setting: Pre	escriber Office Patient's Home	
□ Please provide my patient and/or his/her caregiver with training on the proper self-administration of KINERET®			
□ My patient and/or his/her caregiver has been trained on the proper self-administration of KINERET [®]			
□ I would like to be contacted regarding nursing notes/pharmacy progress reports on the status of this KINERET [®] patient			
KINERET [®] 100 mg/0.67mL Solution □ 28 Syringes □ 7 Syringes □ Other:			
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Directions: Inject mg subcutaneously every Refills:			
□ Dispense as written			
TN prescriber's quantity must be written in both numerals and words. NY prescribers submit prescription on an original NY State prescription blank.			
Proscrib	er Consent		
	r Signature (Required):	Date:	
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I authorize RxCrossroads® to be my designated agent and to act as my business associate (as defined in 45 CFR 160.103) to use, disclose and receive any protected health information (as defined in 45 CFR 160.103) ("PHI") about any of my patients referred to the Sobi Kineret Reimbursement Program ("Patients"), including exchanging such information with pharmacies, insurers, and nurse agencies/coordinators as needed to perform the following services for me: (i) obtain any benefit information about my Patients for the purpose of determining the Patient's insurance coverage for Kineret; (ii) submission of necessary documentation to support Prior Authorization and Pre-Determinations for my Patient's coverage for Kineret; (iii) perform adherence or compliance calls to my Patients related to Kineret treatment. RxCrossroads® may also use and disclose such PHI to assist me with other functions related to my treatment and as otherwise permitted or required by law. As my business associate, RxCrossroads® is required to comply with the applicable requirements of 45 CFR 164.504€(2)(ii)(A) through (I) and 45 CFR 164.44(a)(2)(i)(A) through (C) regarding business associates, and agrees that it will safeguard any PHI that it obtains on my behalf and will use and disclose this information only as permitted herein. RxCrossroads® acknowledges that if it materially breaches its obligations as stated herein, I may terminate its services as stated above and this agreement.			

By signing this form, I certify that I have received the necessary authorization to release the medical and/or other patient information relating to Kineret therapy to RxCrossroads. I authorize RxCrossroads, as operator of patient support services on behalf of Sobi, Inc. and its affiliates, to be my designated agent(s) and (1) to provide any information on this form to the insurer of the

above-named patient and (2) to forward the above prescription, by fax or any other mode of delivery, to the pharmacy.

*Required field.

