Rheumatology

Patient Information

Patient Name:		Date of Birth:	☐ Male ☐ Female
Address:	City:	State:	Zip:
Phone Number:	Alternate Phone Number:	Language:	
Social Security Number:	E-Mail:		
Allergies (Required): ☐ NKDA		Height:	Weight:

Product Shipping Options ☐ Patient's Home ☐ Prescriber Office ☐ Alternative Address:

Insurance: Please fax copy of insurance card (front and back)

Prescriber Information

Practice Name:	Office Contact:	
Prescriber:	NPI:	DEA:
Practice Address:	City:	State:	Zip:
Phone Number:	Fax Number:	

Clinical Notes: Please send last 3 available chart notes and lab results with order

Clinical Information

Diagnosis/ICD-10:	Does the patient have hepatic impairment? ☐ Yes ☐ No	ANC Score: ____/mm^3	Platelet count: _____ /mm^3
Prior Failed Medications: ☐ Methotrexate ☐ Other:	Length of treatment:	Reason for discontinuing:	
Does the patient have a latex allergy? ☐ Yes ☐ No	TB/PPD test given/intended to be given before start? ☐ Yes ☐ No ****Please send documentation**** Is Hepatitis B ruled out? ☐ Yes ☐ No If no, has treatment started? ☐Yes ☐ No		

Prescription Information

Medication	Dose	Directions	Quantity	Refills
☐ Actemra®	162 mg prefilled syringe	Inject 162 mg Sub-Q: ☐ Every other week – OR – ☐ Once a week	☐ 2 PFS ☐ 4 PFS	
☐ Benlysta®	☐ 200 mg autoinjector ☐ 200 mg prefilled syringe	Inject 200 mg Sub-Q once weekly	4 pens/PFS	
☐ Cimzia®	200 mg x 2 prefilled syringe	☐ Starter: Inject 400 mg Sub-Q at week 0, 2, and 4 ☐ Maintenance: Inject 200 mg Sub-Q once every 2 weeks ☐ Maintenance: Inject 400 mg Sub-Q once every 4 weeks	1 starter kit 1 kit	0
☐ Cosentyx®	☐ 150 mg Sensoready® pen ☐ 150 mg prefilled syringe	☐ Starter: Inject 150 mg Sub-Q at week 0, 1, 2, 3, and 4	5 pens/PFS	0
☐ Enbrel®	☐ 50 mg SureClick™ pen ☐ 50 mg prefilled syringe ☐ 50 mg mini cartridge	☐ Maintenance: Inject 150 mg Sub-Q every 4 weeks Inject 50 mg Sub-Q once a week	1 pen /PFS 4 pens/PFS/ cartridges	
☐ Humira®	☐ 40 mg/0.8 mL pen ☐ 40 mg/0.8 mL prefilled syringe	☐ Inject 40 mg Sub-Q every other week ☐ Inject 40 mg Sub-Q once a week	☐ 2 pens/PFS ☐ 4 pens/PFS	
☐ Humira® citrate-free	☐ 40 mg/0.4 mL pen ☐ 40 mg/0.4 mL prefilled syringe	☐ Inject 40 mg Sub-Q every other week ☐ Inject 40 mg Sub-Q once a week	☐ 2 pens/PFS ☐ 4 pens/PFS	
☐ Kevzara®	☐ 200 mg prefilled syringe ☐ 150 mg prefilled syringe	☐ Inject 200 mg Sub-Q once every other week ☐ Inject 150 mg Sub-Q once every other week	2 PFS	
☐ Olumiant®	2 mg tablets	Take 1 tablet by mouth once daily	30 tablets	
☐ Orencia®	☐ 125 mg ClickJect™ autoinjector ☐ 125 mg prefilled syringe	Inject 125 mg Sub-Q once a week	4 pens/PFS	
☐ Otezla®	☐ Starter pack	Take 1 tablet on day 1, then twice daily as directed	1 starter pack	0
	☐ Bridge pack	☐ Take 30 mg by mouth twice daily – OR – ☐ Take 30 mg by mouth once daily	28 tablets	
	☐ 30 mg tablets	☐ Take 30 mg by mouth twice daily **(Titration date: ____/____/_____)**	60 tablets	
☐ Simponi®	☐ 50 mg SmartJect® autoinjector ☐ 50 mg prefilled syringe	Inject 50 mg Sub-Q once a month	1 pen/PFS	
☐ Stelara®	☐ 45 mg prefilled syringe ☐ 90 mg prefilled syringe	☐ Starter: Inject the contents of 1 syringe Sub-Q at week 0, week 4, then every 12 weeks ☐ Maintenance: Inject the contents of 1 syringe Sub-Q every 12 weeks	1 PFS	
☐ Taltz®	☐ 80 mg autoinjector ☐ 80 mg prefilled syringe	☐ Starter: Inject 160 mg Sub-Q at week 0	2 pens/PFS	0
		☐ Maintenance: Inject 80 mg Sub-Q at week 4 and every 4 weeks thereafter	1 pen/PFS	
☐ Xeljanz®	5 mg tablets	Take 1 tablet by mouth twice daily	60	
☐ Xeljanz® XR	11 mg tablets	Take 1 tablet by mouth daily with or without food	30	
☐ Other:				

Prescriber Signature and Date (Please sign and date below)

_____ _____

Substitution Permissible Date Dispense as Written Date

☐ Check here to authorize the receiving pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process and receive forms on the prescriber's behalf. "I certify that the above therapy is medically necessary and the above information is accurate to the best of my knowledge"