

Patient Information – Please attach a copy of the patient's insurance card

Patient Name:		Date of Birth:	<input type="checkbox"/> Male <input type="checkbox"/> Female	
Address:		City:	State:	Zip:
Phone Number:	Alternate Phone Number:		Language:	
Allergies (Required):		<input type="checkbox"/> NKDA	Height:	Weight:
SSN:				
Product Shipping Options: <input type="checkbox"/> Patient's Home <input type="checkbox"/> Prescriber Office <input type="checkbox"/> Alternative Address:				

Prescriber Information

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

Clinical Information – Please send all available chart notes including lab results

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

Prescription Information

Medication	Dose	Directions	Quantity	Refills
<input type="checkbox"/> Actemra®	162 mg prefilled syringe	Inject 162 mg Sub-Q: <input type="checkbox"/> Once a week (> 100 kg) – OR – <input type="checkbox"/> Every other week (< 100 kg)	<input type="checkbox"/> 2 PFS <input type="checkbox"/> 4 PFS	
<input type="checkbox"/> Benlysta®	<input type="checkbox"/> 200 mg prefilled syringe <input type="checkbox"/> 200 mg autoinjector	Inject 200 mg Sub-Q once weekly	4 PFS	
<input type="checkbox"/> Cimzia®	<input type="checkbox"/> 200 x 2 prefilled syringe	Initial: <input type="checkbox"/> Inject 400 mg Sub-Q at week 0, 2, and 4	1 starter pack	0
		Maintenance: <input type="checkbox"/> Inject 400 mg Sub-Q once every 4 weeks OR <input type="checkbox"/> Inject 200 mg Sub-Q once every 2 weeks	1 kit	
<input type="checkbox"/> Cosentyx®	<input type="checkbox"/> 150 mg/mL Sensoready® pen <input type="checkbox"/> 150 mg/mL prefilled syringe	With a loading dose: <input type="checkbox"/> Inject 150 mg Sub-Q at week 0, 1, 2, 3, and 4 then every 4 weeks thereafter	4 PFS/pens	
		Without a loading dose: <input type="checkbox"/> Inject 150 mg Sub-Q every 4 weeks	1 PFS/pen	
<input type="checkbox"/> Enbrel®	<input type="checkbox"/> 25 mg powder vial <input type="checkbox"/> 25 mg prefilled syringe <input type="checkbox"/> 50 mg SureClick™ <input type="checkbox"/> 50 mg prefilled syringe	<input type="checkbox"/> Inject 50 mg Sub-Q once a week <input type="checkbox"/> Inject ____ mg Sub-Q once a week (0.8 mg/kg)	<input type="checkbox"/> 4 PFS/pens	
<input type="checkbox"/> Humira®	<input type="checkbox"/> 40 mg pen <input type="checkbox"/> 40 mg prefilled syringe	<input type="checkbox"/> Inject 40 mg Sub-Q every other week <input type="checkbox"/> Inject 40 mg Sub-Q once a week	<input type="checkbox"/> 2 PFS/pens <input type="checkbox"/> 4 PFS/pens	
<input type="checkbox"/> Kevzara®	<input type="checkbox"/> 200 mg prefilled syringe <input type="checkbox"/> 150 mg prefilled syringe	<input type="checkbox"/> Inject 200 mg Sub-Q once every other week <input type="checkbox"/> Inject 150 mg Sub-Q once every other week	2 PFS	
<input type="checkbox"/> Orencia®	<input type="checkbox"/> ____ mg prefilled syringe <input type="checkbox"/> 125 mg prefilled syringe <input type="checkbox"/> 125 mg autoinjector	Inject ____ mg Sub-Q once a week (<i>weight-based dosing</i>)	4 PFS	
<input type="checkbox"/> Otezla®	<input type="checkbox"/> Starter pack	<input type="checkbox"/> Titration: take 1 tablet on day 1, then twice daily as directed	1 starter pack	0
	<input type="checkbox"/> Bridge Pack	<input type="checkbox"/> Take 30 mg by mouth once daily <input type="checkbox"/> Take 30 mg by mouth twice daily	28 tabs	
	<input type="checkbox"/> 30 mg tablets	<input type="checkbox"/> Take 1 tablet by mouth twice daily (<i>Titration date: ____ / ____ / ____</i>)	60 tabs	
<input type="checkbox"/> Simponi®	<input type="checkbox"/> 50 mg SmartJect® <input type="checkbox"/> 50 mg prefilled syringe	Inject 50 mg Sub-Q once a month as directed	1 PFS	
<input type="checkbox"/> Stelara®	<input type="checkbox"/> 45 mg prefilled syringe (< 100 kg) <input type="checkbox"/> 90 mg prefilled syringe (>100 kg)	Inject contents of 1 syringe Sub-Q initially and 4 weeks later, and then every 12 weeks	1 PFS	
<input type="checkbox"/> Xeljanz®	5 mg tablets	Take 1 tablet by mouth twice daily	60 tabs	
<input type="checkbox"/> Xeljanz® XR	11 mg tablets	Take 1 tablet by mouth daily with or without food	30 tabs	
<input type="checkbox"/> Other:				

Prescriber Signature and Date (Please sign and date below)

Dispense as Written	Date	Substitution Permissible	Date
<input type="checkbox"/> Check here to authorize Curexa® 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"			