



PATIENT INFORMATION	Patient Name: _____	PRESCRIBER INFORMATION	Prescriber's Name: _____
	Address: _____		State License #: _____ NPI #: _____
	City: _____ State: _____ Zip: _____		DEA #: _____
	Primary Phone: _____ DOB: _____		Group or Hospital: _____
	Alternate Phone: _____ Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		Address: _____
	Email: _____		City: _____ State: _____ Zip: _____
	Last Four of SS #: _____ Primary Language: _____		Phone: _____ Fax: _____
	Height: _____ Weight: _____		Contact Person: _____ Phone: _____

INSURANCE INFORMATION: PLEASE FAX A COPY OF THE PRESCRIPTION & INSURANCE CARDS WITH THIS FORM, IF AVAILABLE (FRONT & BACK)

CLINICAL	Need By Date: _____ Ship to: <input type="checkbox"/> Patient <input type="checkbox"/> Physician <input type="checkbox"/> Other: _____	
	Date of Diagnosis: _____ Diagnosis: <input type="checkbox"/> M06.9 Rheumatoid Arthritis <input type="checkbox"/> M45.9 Ankylosing Spondylitis <input type="checkbox"/> L40.54 Psoriatic Arthritis <input type="checkbox"/> M08 Juvenile Idiopathic Arthritis	
	<input type="checkbox"/> Other: _____	
	Prior Medications: <input type="checkbox"/> Acetaminophen, ibuprofen, naproxen, aspirin <input type="checkbox"/> Humira <input type="checkbox"/> Enbrel <input type="checkbox"/> Methotrexate <input type="checkbox"/> Corticosteroids <input type="checkbox"/> Hydroxychloroquine	
	<input type="checkbox"/> Leflunomide <input type="checkbox"/> Sulfasalazine <input type="checkbox"/> Other meds tried: _____	
	Current Medications: _____	Is the patient also taking methotrexate? <input type="checkbox"/> Yes <input type="checkbox"/> No
Allergies: _____	Is the patient new to therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Has patient had positive TB test? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date of last chest x-ray: _____	Is a starter dose needed? <input type="checkbox"/> Yes <input type="checkbox"/> No	

	MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILL
PRESCRIPTION INFORMATION	<input type="checkbox"/> Cimzia®	<input type="checkbox"/> Starter Kit (200 mg Prefilled Syringes) <input type="checkbox"/> 200mg/ml Prefilled Syringe <input type="checkbox"/> 200mg Vial	<input type="checkbox"/> 400mg Sub-Q at weeks 0, 2, and 4 <input type="checkbox"/> 400mg Sub-Q every 4 weeks <input type="checkbox"/> 200mg Sub-Q every 2 weeks <input type="checkbox"/> Other: _____	<input type="checkbox"/> 1 Kit = 6 x 200 mg/mL PFS <input type="checkbox"/> 1 Carton = 2 x 200 mg/mL PFS <input type="checkbox"/> 1 Carton = 2 x 200 mg Vials	0 _____ _____
	<input type="checkbox"/> Enbrel®	<input type="checkbox"/> 50mg/ml Sureclick™ <input type="checkbox"/> 50mg/ml Prefilled Syringe <input type="checkbox"/> 25mg/0.5ml Prefilled Syringe <input type="checkbox"/> 25mg Vial	<input type="checkbox"/> Inject 50mg Sub-Q ONCE a week <input type="checkbox"/> Inject 25mg Sub-Q TWICE a week (72-96 hours apart). <input type="checkbox"/> Inject 50mg Sub-Q TWICE a week (72-96 hours apart).	<input type="checkbox"/> 4 <input type="checkbox"/> 8	_____ _____
	<input type="checkbox"/> Humira®	<input type="checkbox"/> 40mg/0.8ml Pen <input type="checkbox"/> 40mg/0.8ml Prefilled Syringe	<input type="checkbox"/> Inject 40mg Sub-Q every OTHER week <input type="checkbox"/> Inject 40mg Sub-Q every week	<input type="checkbox"/> 2 <input type="checkbox"/> 4	_____ _____
	<input type="checkbox"/> Actemra®	<input type="checkbox"/> 162mg/0.9ml Prefilled Syringe	<input type="checkbox"/> Inject 162mg Sub-Q every OTHER week <input type="checkbox"/> Inject 162mg Sub-Q every week	<input type="checkbox"/> 2 <input type="checkbox"/> 4	_____ _____
	<input type="checkbox"/> Orencia®	<input type="checkbox"/> 250mg Vial (IV use only) <input type="checkbox"/> 125 mg Prefilled Syringe <input type="checkbox"/> 125 mg Autoinjector	<input type="checkbox"/> 10mg/kg IV x 1 dose, then 125mg Sub-Q weekly, start within 24hrs of IV dose <input type="checkbox"/> Other: _____ <input type="checkbox"/> 125mg Sub-Q ONCE a week <input type="checkbox"/> 125mg Sub-Q ONCE a week	<input type="checkbox"/> 1 Vial <input type="checkbox"/> 4 Syringes <input type="checkbox"/> 4 Pens	_____ _____ _____
	<input type="checkbox"/> Simponi®	<input type="checkbox"/> 50mg/0.5ml Autoinjector <input type="checkbox"/> 50mg/0.5ml Prefilled Syringe <input type="checkbox"/> 100mg/ml Syringe <input type="checkbox"/> 100mg/ml Autoinjector	<input type="checkbox"/> Inject 1 dose Sub-Q once monthly <input type="checkbox"/> Other: _____	<input type="checkbox"/> 1 (one)	_____ _____
	<input type="checkbox"/> Cosentyx®	<input type="checkbox"/> 150mg/mL Prefilled Syringe <input type="checkbox"/> 150mg/mL Pen	<input type="checkbox"/> Starter Dose: Inject 300mg Sub-Q Day 1, Day 8, Day 15, Day 22, and then every 4 weeks starting on Day 29 <input type="checkbox"/> Starter dose: Inject 150mg Sub-Q Day 1, Day 8, Day 15, Day 22, and then every 4 weeks starting on Day 29 <input type="checkbox"/> Maintenance Dose: Inject the contents of 300mg Sub-Q starting Day 29 & then every 4 weeks thereafter <input type="checkbox"/> Maintenance Dose: Inject the contents of 150mg Sub-Q starting Day 29 & then every 4 weeks thereafter	<input type="checkbox"/> 8 <input type="checkbox"/> 4 <input type="checkbox"/> 2 <input type="checkbox"/> 2	0 0 _____ _____
	<input type="checkbox"/> Stelara®	<input type="checkbox"/> 45mg/0.5mL Prefilled Syringe <input type="checkbox"/> 90mg/1mL Prefilled Syringe	<input type="checkbox"/> Starter Dose: Inject 1 prefilled syringe Sub-Q Day 1 <input type="checkbox"/> Maintenance Dose: Inject the contents of 1 prefilled syringe Sub-Q starting Day 29 & every 12 weeks thereafter	<input type="checkbox"/> 1 PFS <input type="checkbox"/> 1 PFS	0 _____ _____
	<input type="checkbox"/> Xeljanz®	<input type="checkbox"/> 5mg Tab <input type="checkbox"/> 11mg XR Tab	<input type="checkbox"/> Take one 5mg tablet PO twice daily <input type="checkbox"/> Take one 11mg XR tablet PO once daily <input type="checkbox"/> Other: _____	<input type="checkbox"/> 60 <input type="checkbox"/> 30	_____ _____
	<input type="checkbox"/> Otezla®	<input type="checkbox"/> Cimzia Starter Kit <input type="checkbox"/> Cimzia 30mg Tablet	<input type="checkbox"/> Starter Dose: Take as directed per package instructions <input type="checkbox"/> Maintenance Dose: Take 1 tablet by mouth twice daily	<input type="checkbox"/> 55 <input type="checkbox"/> 60	0 _____ _____
	<input type="checkbox"/> Remicade®	<input type="checkbox"/> Remicade 100mg vial	<input type="checkbox"/> Induction: Infuse _____mg IV at weeks 0, 2, and 6 <input type="checkbox"/> Maintenance: Infuse _____mg IV at every 8 weeks	<input type="checkbox"/> _____ # Vial(s)	_____ _____
	<input type="checkbox"/> Kevzara®	<input type="checkbox"/> 150mg/1.14ml Prefilled Syringe <input type="checkbox"/> 200mg/1.14ml Prefilled Syringe	<input type="checkbox"/> Inject 200mg Sub-Q every OTHER week <input type="checkbox"/> Inject 150mg Sub-Q every OTHER week	<input type="checkbox"/> 2	_____ _____

X	X
PRODUCT SUBSTITUTION PERMITTED (Date) _____	DISPENSE AS WRITTEN (Date) _____

Date Needed: _____ Medication Start Date: _____

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