



<b>PATIENT INFORMATION</b>	Patient Name: _____	<b>PRESCRIBER INFORMATION</b>	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)**

<b>CLINICAL</b>	<b>Need By Date:</b> _____ <b>Ship to:</b> <input type="checkbox"/> Patient <input type="checkbox"/> Physician <input type="checkbox"/> Other: _____
	<b>Date of Diagnosis:</b> _____ <b>Diagnosis:</b> <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: _____
	<b>Prior Medications:</b> <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: _____
	<b>Current Medications:</b> _____ <b>Is the patient also taking methotrexate?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
	<b>Allergies:</b> _____ <b>Is the patient new to therapy?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Has patient had positive TB test?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If yes, date of last chest x-ray:</b> _____ <b>Is a starter dose needed?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILL
<input type="checkbox"/> Cimzia®	<input type="checkbox"/> Starter Kit (200 mg Prefilled Syringes)	<input type="checkbox"/> 400mg Sub-Q at weeks 0, 2, and 4	<input type="checkbox"/> 1 Kit = 6 x 200 mg/mL PFS	0
	<input type="checkbox"/> 200mg/ml Prefilled Syringe <input type="checkbox"/> 200mg Vial	<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 Carton = 2 x 200 mg/mL PFS <input type="checkbox"/> 1 Carton = 2 x 200 mg Vials	_____
<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"/> 8 <input type="checkbox"/> 4 <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)	_____

<b>X</b>	<b>X</b>
PRODUCT SUBSTITUTION PERMITTED (Date) _____	DISPENSE AS WRITTEN (Date) _____

Date Needed: \_\_\_\_\_ Medication Start Date: \_\_\_\_\_

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