

## PATIENT INFORMATION

Patient Name:		Prescriber:	
Street Address:		NPI:	
City, State, Zip:		Group:	
Phone #1:		Street Address:	
Phone #2:		City, State, Zip:	
Social Security:		Office Phone:	
Date of Birth:	/ /	Office FAX:	
Sex:	<input type="checkbox"/> M <input type="checkbox"/> F	Primary Contact:	

## PLEASE SEND INSURANCE CARD AND DEMOGRAPHIC INFORMATION

**DIAGNOSIS (ICD-10)**

M45.\_\_\_\_ Ankylosing Spondylitis       M08.\_\_\_\_ JIA       M32.9 SLE

L40.\_\_\_\_ Psoriatic Arthritis       M06.\_\_\_\_ Rheumatoid Arthritis       H20.\_\_\_\_ Uveitis

## CURRENT / PREVIOUS THERAPIES FOR THIS CONDITION

DMARDs       Azathioprine     Leflunomide     Methotrexate     Plaquenil     Sulfasalazine     Rasuvo/Otrexup

Biologics       Actemra     Benlysta     Cimzia     Cosentyx     Enbrel     Humira     Olumiant     Orenzia     Otezla

Otezla     Remicade     Rinvoq     Rituxan     Simponi     Stelara     Taltz     Tremfya     Xeljanz

PPD/Chest X-Ray for TB?     Yes     No    Drug Allergies:

## PRESCRIPTION INFORMATION

<input type="checkbox"/> Actemra SC	<input type="checkbox"/> 162mg/0.9ml PFS <input type="checkbox"/> 162mg/0.9ml ACTPen	<input type="checkbox"/> 162mg SQ every other week (qty 2) <input type="checkbox"/> 162mg SQ once weekly (qty 4)	Refill:
<input type="checkbox"/> Benlysta SC	<input type="checkbox"/> 200mg autoinjector <input type="checkbox"/> 200mg PFS	<input type="checkbox"/> Inject 200mg once weekly	Refill:
<input type="checkbox"/> Cimzia	<input type="checkbox"/> 200x2 PFS <input type="checkbox"/> 200x2 LYO	<input type="checkbox"/> Start: Inject 400mg SQ at weeks 0, 2, and 4 (qty 3 kits) <input type="checkbox"/> Maint: Inject _____mg SQ every: <input type="checkbox"/> 2 <input type="checkbox"/> 4 wks (qty _____)	Refill: 0 Refill:
<input type="checkbox"/> Cosentyx	<input type="checkbox"/> 150mg Sensoready PEN <input type="checkbox"/> 150mg PFS	<input type="checkbox"/> Start: Inject _____mg SQ at weeks 0, 1, 2, 3 and 4 (qty _____) <input type="checkbox"/> Maint: Inject _____mg SQ every 4 weeks (qty _____)	Refill: 0 Refill:
<input type="checkbox"/> Enbrel	<input type="checkbox"/> 50mg Enbrel Mini <input type="checkbox"/> 50mg Sureclick <input type="checkbox"/> 25mg <input type="checkbox"/> 50mg PFS	<input type="checkbox"/> Inject 50mg SQ TWICE a week, 72-96 hrs apart (qty 8) <input type="checkbox"/> Inject 50mg SQ ONCE a week (qty 4) <input type="checkbox"/> Inject 25mg SQ TWICE a week, 72-96 hrs apart (qty 8)	Refill:
<input type="checkbox"/> Humira <i>Citrate free</i>	<input type="checkbox"/> 40mg/0.4ml PEN <input type="checkbox"/> 40mg/0.4ml PFS <input type="checkbox"/> 80mg/0.8ml PEN	<input type="checkbox"/> Inject 80mg SQ Day 1, 40mg Day 8, then 40mg every-other-week (qty 4/2) <input type="checkbox"/> Inject 40mg SQ every _____ week(s) (qty _____) <input type="checkbox"/> Inject 80mg SQ every _____ week(s) (qty _____)	Refill:
<input type="checkbox"/> Kevzara	150mg <input type="checkbox"/> PFS <input type="checkbox"/> PEN 200mg <input type="checkbox"/> PFS <input type="checkbox"/> PEN	<input type="checkbox"/> Inject _____mg SQ every 2 weeks (qty 2)	Refill:
<input type="checkbox"/> Olumiant	<input type="checkbox"/> 2mg Tablet	<input type="checkbox"/> Take 1 tablet by mouth once daily (qty 30)	Refill:
<input type="checkbox"/> Orenzia	<input type="checkbox"/> 125mg ClickJect <input type="checkbox"/> 125mg PFS	<input type="checkbox"/> Inject 125mg SQ ONCE a week (qty 4)	Refill:
<input type="checkbox"/> Otezla	<input type="checkbox"/> Starter Kit <input type="checkbox"/> 30mg Tablet	<input type="checkbox"/> Take Starter Dosing per instructions (qty 55 // 28 days) [ <input type="checkbox"/> Office provided] <input type="checkbox"/> Take 1 tablet by mouth twice daily (qty 60 // 30 days)	Refill: 0 Refill:
<input type="checkbox"/> Rinvoq	<input type="checkbox"/> 15mg Tablet	<input type="checkbox"/> Take 1 tablet by mouth once daily (qty 30)	Refill:
<input type="checkbox"/> Simponi	<input type="checkbox"/> 50mg SmartJect <input type="checkbox"/> 50mg PFS	<input type="checkbox"/> Inject 50mg SQ every 4 weeks (qty 1)	Refill:
<input type="checkbox"/> Stelara	<input type="checkbox"/> 45mg PFS <input type="checkbox"/> 90mg PFS	<input type="checkbox"/> Start: Inject _____mg SQ day 0, then on day 28 (qty 2) <input type="checkbox"/> Maint: Inject _____mg SQ every 12 weeks (qty 1)      *Pt. weight _____ lbs	Refill: 0 Refill:
<input type="checkbox"/> Taltz	<input type="checkbox"/> 80mg Autoinjector <input type="checkbox"/> 80mg PFS	<input type="checkbox"/> Start: Inject 2-80mg (160mg) SQ at Week 0, then every 4 weeks (qty 2) <input type="checkbox"/> Maint: Inject 80mg SQ every 4 weeks (qty 1)	Refill: 0 Refill:
<input type="checkbox"/> Tremfya	<input type="checkbox"/> 100mg Autoinjector <input type="checkbox"/> 100mg PFS	<input type="checkbox"/> Start: Inject 100mg SQ at Week 0, then on day 28 (qty 2) <input type="checkbox"/> Maint: Inject 100mg SQ every 8 weeks (qty 1)	Refill: 0 Refill:
<input type="checkbox"/> Xeljanz	<input type="checkbox"/> 5mg Tablet	<input type="checkbox"/> Take 5mg orally twice daily as directed (qty 60)	Refill:
<input type="checkbox"/> Xeljanz XR	<input type="checkbox"/> 11mg Tablet	<input type="checkbox"/> Take 11mg orally once daily as directed (qty 30)	Refill:

PRESCRIBER SIGNATURE \_\_\_\_\_ DATE \_\_\_\_ / \_\_\_\_ / \_\_\_\_

PRODUCT SUBSTITUTION PERMITTED      DISPENSE AS WRITTEN