

PATIENT INFORMATION

Patient Name:		Prescriber:	
Street Address:		NPI:	
City, State, Zip:		Street Address:	
Phone:		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 M0 ___ 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
 Remicade Rinvoq Rituxan Simponi Skyrizi 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 Syringe <input type="checkbox"/> 162mg/0.9ml Pen	<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 Syringe	<input type="checkbox"/> Inject 200mg once weekly	Refill:
<input type="checkbox"/> Cimzia	<input type="checkbox"/> 200x2 Syringe Kit	<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 Syringe	<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 <input type="checkbox"/> Amjevita	<input type="checkbox"/> 40mg/0.4ml Pen <input type="checkbox"/> 40mg/0.4ml Syringe <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 Syringe	<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 Syringe	<input type="checkbox"/> Inject 50mg SQ every 4 weeks (qty 1)	Refill:
<input type="checkbox"/> Skyrizi	<input type="checkbox"/> 150mg Autoinjector <input type="checkbox"/> 150mg Syringe	<input type="checkbox"/> Start: Inject 150mg SQ at Week 0, then on day 28 (qty 2) <input type="checkbox"/> Maint: Inject 150mg SQ every 12 weeks (qty 1)	Refill: 0 Refill:
<input type="checkbox"/> Stelara	<input type="checkbox"/> 45mg Syringe <input type="checkbox"/> 90mg Syringe	<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 Syringe	<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 Syringe	<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 <input type="checkbox"/> 11mg XR	<input type="checkbox"/> Take ___mg Tablet by Mouth <input type="checkbox"/> Twice Daily <input type="checkbox"/> Once Daily	Refill:

PRESCRIBER SIGNATURE _____ DATE ___ / ___ / ___

PRODUCT SUBSTITUTION PERMITTED DISPENSE AS WRITTEN