APEX SPECIALTY PHARMACY

RHEUMATOLOGY

Phone: 855.257.2584 || Fax: 866.680.3539

Date _____
☐ NEW START
☐ CONTINUATION / Start Date: _____

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:	☐ M ☐ 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 ☐ Orencia ☐ Otezla ☐ Remicade ☐ Rinvoq ☐ Rituxan ☐ Simponi ☐ Skyrizi ☐ Stelara ☐ Taltz ☐ Tremfya ☐ Xeljanz

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

PRESCRIPTION INFORMATION

☐ Actemra SC	☐ 162mg/0.9ml Syringe ☐ 162mg/0.9ml Pen	☐ 162mg SQ every other week (qty 2) ☐ 162mg SQ once weekly (qty 4)	Refill:
☐ Benlysta SC	☐ 200mg Autoinjector ☐ 200mg Syringe	☐ Inject 200mg once weekly	Refill:
☐ Cimzia	☐ 200x2 Syringe Kit	☐ Start: Inject 400mg SQ at weeks 0, 2, and 4 (qty 3 kits) ☐ Maint: Inject _____mg SQ every: ☐ 2 ☐ 4 wks (qty _____)	Refill: 0 Refill:
☐ Cosentyx	☐ 150mg Sensoready Pen ☐ 150mg PFS ☐ 300mg UnoReady PEN	☐ Start: Inject _____mg SQ at weeks 0, 1, 2, 3 and 4 (qty _____) ☐ Maint: Inject _____mg SQ every 4 weeks (qty _____)	Refill: 0 Refill:
☐ Enbrel	☐ 50mg Enbrel Mini ☐ 50mg Sureclick ☐ 25mg ☐ 50mg Syringe	☐ Inject 50mg SQ TWICE a week, 72-96 hrs apart (qty 8) ☐ Inject 50mg SQ ONCE a week (qty 4) ☐ Inject 25mg SQ TWICE a week, 72-96 hrs apart (qty 8)	Refill:
☐ Humira ☐ Biosimilar: _____	☐ 40mg/0.4ml Pen ☐ 40mg/0.4ml Syringe ☐ 80mg/0.8ml Pen	☐ Inject 80mg SQ Day 1, 40mg Day 8, then 40mg every-other-week (qty 4/2) ☐ Inject 40mg SQ every ____ week(s) (qty ____) ☐ Inject 80mg SQ every ____ week(s) (qty ____)	Refill:
☐ Kevzara	150mg ☐ PFS ☐ Pen 200mg ☐ PFS ☐ Pen	☐ Inject _____mg SQ every 2 weeks (qty 2)	Refill:
☐ Olumiant	☐ 2mg Tablet	☐ Take 1 tablet by mouth once daily (qty 30)	Refill:
☐ Orencia	☐ 125mg ClickJect ☐ 125mg Syringe	☐ Inject 125mg SQ ONCE a week (qty 4)	Refill:
☐ Otezla	☐ Starter Kit ☐ 30mg Tablet	☐ Take Starter Dosing per instructions (qty 55 // 28 days) [☐ *Office provided*] ☐ Take 1 tablet by mouth twice daily (qty 60 // 30 days)	Refill: 0 Refill:
☐ Rinvoq	☐ 15mg Tablet	☐ Take 1 tablet by mouth once daily (qty 30)	Refill:
☐ Simponi	☐ 50mg SmartJect ☐ 50mg Syringe	☐ Inject 50mg SQ every 4 weeks (qty 1)	Refill:
☐ Skyrizi	☐ 150mg Autoinjector ☐ 150mg Syringe	☐ Start: Inject 150mg SQ at Week 0, then on day 28 (qty 2) ☐ Maint: Inject 150mg SQ every 12 weeks (qty 1)	Refill: 0 Refill:
☐ Stelara	☐ 45mg Syringe ☐ 90mg Syringe	☐ Start: Inject ____mg SQ day 0, then on day 28 (qty 2) ☐ Maint: Inject ____mg SQ every 12 weeks (qty 1) **Pt. weight _____lbs*	Refill: 0 Refill:
☐ Taltz	☐ 80mg Autoinjector ☐ 80mg Syringe	☐ Start: Inject 2-80mg (160mg) SQ at Week 0, then every 4 weeks (qty 2) ☐ Maint: Inject 80mg SQ every 4 weeks (qty 1)	Refill: 0 Refill:
☐ Tremfya	☐ 100mg Autoinjector ☐ 100mg Syringe	☐ Start: Inject 100mg SQ at Week 0, then on day 28 (qty 2) ☐ Maint: Inject 100mg SQ every 8 weeks (qty 1)	Refill: 0 Refill:
☐ Xeljanz	☐ 5mg ☐ 11mg XR	☐ Take _____ mg Tablet by Mouth ☐ Twice Daily ☐ Once Daily	Refill:

PRESCRIBER SIGNATURE _____ _____ DATE ____ / ____ / ____

PRODUCT SUBSTITUTION PERMITTED DISPENSE AS WRITTEN