Rheumatology L-Z

Select Location

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DATE: _____ NEEDS BY DATE: _____ SHIP TO: ❑ PATIENT ❑ OFFICE - FIRST DOSE ❑ OFFICE - ALL DOSES ❑ OTHER _____

PATIENT INFORMATION

Patient Name		
Address		
City	State	Zip
Main Phone	Alternative Phone	❑ Male ❑ Female
Social Security #		Date of Birth

PRESCRIBER INFORMATION

Prescriber Name		
Prescriber Type	❑ Physician (MD or DO) ❑ Nurse Practitioner	❑ Physician's Assistant
Supervising Physician (If prescriber is a NP or PA)		
DEA #	NPI #	Tax ID #
Address		
City	State	Zip
Phone	Fax	
Contact Person		

CLINICAL INFORMATION

Diagnosis: ❑ M06.9 Rheumatoid Arthritis ❑ H20.0 Iridocyclitis (Uveitis)	❑ L40.50 Psoriatic Arthritis ❑ Other: _____	❑ M45.9 Ankylosing Spondylitis DX Code: _____	❑ M08.00 Juvenile Rheumatoid Arthritis
Patient Allergies:		Hepatitis Test Result:	Patient Weight: Patient Height:
TB/PPD Test given? ❑ Yes ❑ No Test Date:		Test Results:	
Prior Failed Meds: ❑ Actemra ❑ Cosentyx ❑ Cimzia ❑ Enbrel ❑ Humira ❑ Kevzara ❑ Orencia ❑ Otezla			
Methotrexate Length of Treatment:_____		Reason for Discontinuing:_____	
_____ Length of Treatment:_____		Reason for Discontinuing:_____	
_____ Length of Treatment:_____		Reason for Discontinuing:_____	
Additional Information:			

INSURANCE: PLEASE FAX BOTH SIDES OF PRESCRIPTION CARD AND MEDICAL CARD

PRESCRIPTION INFORMATION			QUANTITY	REFILLS
❑ Olumiant	❑ 1 mg ❑ 2 mg	Take 1 tablet by mouth daily	30	_____
❑ Orencia®	❑ 125mg PFS ❑ 250mg Vials ❑ 125mg Auto-Injector	❑ Inject 125mg SQ ONCE a week ❑ Infuse _____mg at _____	4 Week Supply	_____
❑ Otezla®	❑ Starter Pack ❑ 30mg Tablets	❑ **Titrate:** Take 1 tablet on day 1 then twice daily as directed **OR date provided** _____ ❑ **Maintenance:** Take 1 tablet by mouth **ONCE** daily ❑ **Maintenance:** Take 1 tablet by mouth **TWICE** daily.	1 Starter Pack 30 60	_____
❑ Otezla® *Bridge Rx*	30mg Tablets	❑ Bridge Rx: Take 1 tablet by mouth **TWICE** daily; dispensed by OSP **(Recommended daily dose) ***Starter Pack Provided Date:** _____ ❑ Bridge Rx: Take 1 tablet by mouth **ONCE** daily; dispensed by OSP **(For Patients with severe renal impairment)**	28	_____
❑ Remicade®	100mg Vial	Infuse _____mg at _____	_____	_____
❑ Rinvoq™	Please utilize manufacturer enrollment form and send to Avita			
❑ Simponi®	❑ 50mg SmartJect or ❑ PFS ❑ Aria	❑ Inject 50mg SQ ONCE a MONTH as directed ❑ Infuse _____mg at weeks 0 and 4, then every 8 weeks thereafter	4 Week Supply	_____
❑ Stelara®	❑ 45mg Prefilled Syringe ❑ 90mg Prefilled Syringe **Weight Required:** _____	❑ Inject 45mg on day 0, then week 4, then every 12 weeks **(Patients ≤ 220lbs)** ❑ Inject 90mg on day 0, then week 4, then every 12 weeks **(Patients > 220lbs)**	4 Week Supply	_____
❑ Taltz® *Psoriatic Arthritis Only*	❑ Auto Injector ❑ Pre-filled Syringe	❑ **Initial:** Inject 160 mg SQ on week 0 ❑ **Maintenance:** Inject 80 mg SQ every 4 weeks	2 1	_____
❑ Xeljanz®	❑ 5mg Tablets ❑ 11mg XR Tablets	❑ Take 1 tablet by mouth **TWICE** daily ❑ Take 1 tablet my mouth **ONCE** daily	60 30	_____
❑ Otrexup®			4 Week Supply	_____
❑ Rasuvo®			4 Week Supply	_____

Dispense As Written (no stamps) **Date** **Substitution Permitted** (no stamps) **Date**

1. In order for a brand name product to be dispensed, the prescriber must write "Brand Necessary" or "Brand Medically Necessary" or any required state-specific language.
2. By signing this form, you are authorizing the pharmacy and its representatives to act on your behalf to obtain prior authorizations for the prescribed medication(s). We will also pursue available copay and financial assistance on behalf of your patients when available.
3. The pharmacy can only accept faxed prescriptions directly from a prescriber's office.
4. Prescribers must comply with any of their state-specific prescription requirements.