# Rheumatology A-K

Select Pharmacy

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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 ❑ M32 Systemic Lupus Erythematosus (SLE) | ❑ M45.9 Ankylosing Spondylitis ❑ Other: _____ | ❑ M08.00 Juvenile Rheumatoid Arthritis DX Code: _____ |
| 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:_____ | |
| **Hydroxychloroquine** 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

LEFT BLANK

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.

| PATIENT INFORMATION | | |
|---|---|---|
| Patient Name | Date of Birth | Prescription Date |
| | | |

| PRESCRIPTION INFORMATION | | | | QUANTITY | REFILLS |
|---|---|---|---|---|---|
| ❑ Actemra® | ❑ Pre-filled Syringe<br>❑ Pre-filled Pen | ❑ **SQ:** Inject 162 mg SQ every **other** week<br>❑ **SQ:** Inject 162 mg SQ every week | | 4 Week Supply | _____ |
| ❑ Benlysta® | ❑ Vials ❑ 120mg/5ml ❑ 400mg/20ml<br>❑ Prefilled Syringe<br>❑ Auto-Injector Pen | ❑ **IV INITIAL:** Infuse _____mg or 10mg/kg IV every 2 weeks for 3 doses<br>❑ **IV MAINTENANCE:** Infuse _____mg or 10mg/kg IV every 4 weeks<br>❑ **SQ:** Inject 200mg SQ every 4 weeks | | 3 Doses<br>4 Week Supply<br>4 Week Supply | _____ |
| ❑ Cosentyx™ | ❑ SensorReady Pen<br>❑ Prefilled Syringe | ❑ **INITIAL:** Inject 150mg SQ on week 0,1,2,3, & 4 (Qty 5)<br>❑ **INITIAL:** Inject 300mg SQ on week 0,1,2,3, & 4 (Qty 10) | ❑ **MAINTENANCE:** Inject 150 mg SQ every 4 weeks (Qty 1)<br>❑ **MAINTENANCE:** Inject 300 mg SQ every 4 weeks (Qty 2) | | _____ |
| ❑ Cosentyx™ *Covered Until You're Covered* | ❑ SensorReady Pen<br>❑ Prefilled Syringe | ❑ **INITIAL:** Inject 150mg SQ on week 0,1,2,3, & 4 (Qty 5)<br>❑ **INITIAL:** Inject 300mg SQ on week 0,1,2,3, & 4 (Qty 10) | ❑ **MAINTENANCE:** Inject 150 mg SQ every 4 weeks (Qty 1)<br>❑ **MAINTENANCE:** Inject 300 mg SQ every 4 weeks (Qty 2) | | _____ |
| ❑ Cimzia® | ❑ Prefilled Syringe<br>❑ Vials | ❑ **INITIAL:** Inject 400 mg SQ at Day 0, Day 14, and Day 28<br>❑ **MAINTENANCE:** Inject 400 mg SQ every 4 weeks<br>❑ **MAINTENANCE:** Inject 200 mg SQ every 2 weeks | | 1 Starter Kit<br>4 Week Supply | _____ |
| ❑ Enbrel® | ❑ SureClick® Pen<br>❑ Mini™ with AutoTouch™<br>❑ Prefilled Syringe<br>❑ 25 mg ❑ 50 mg<br>❑ Vials 25 mg | ❑ Inject 50 mg SQ every week<br>❑ Inject 25 mg twice weekly 72-96 hours apart | | 4 Week Supply | _____ |
| ❑ **Humira®** ***Citrate Free*** | ❑ Uveitis Starter Kit<br>❑ Pen<br>❑ Pre-filled Syringe | ❑ **UVEITIS INITIAL:** Inject 80mg SQ on Day 1, 40mg on Day 8, then 40mg every **other** week<br>❑ **MAINTENANCE:** Inject 40mg SQ every **other** week<br>❑ **MAINTENANCE:** Inject 40mg SQ weekly | | 3<br>2<br>4 | _____ |
| ❑ Kevzara® | ❑ Pen<br>❑ 150 mg ❑ 200 mg<br>❑ Prefilled Syringe<br>❑ 150 mg ❑ 200 mg | ❑ Inject 150 mg SQ every 2 weeks<br>❑ Inject 200 mg SQ every 2 weeks | | 4 Week Supply | _____ |

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

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4. Prescribers must comply with any of their state-specific prescription requirements.