Pharmacy Fax Number: _____

Faxed by: _____

RHEUMATOLOGY
Prescription Form

Prescription Authorization

Completed ☐

Today's Date _____ **Physician's Signature** _____ **(must be a wet signature)**

Prescriber Information

Completed ☐

First Name_____ Last Name_____ NPI#_____ DEA#_____ Lic #_____

Practice Name_____ Specialty_____

Address_____ City_____ State_____ ZIP_____

Phone_____ Fax _____ Email _____

Contact Person_____ Title_____ Direct Line_____ Ext_____

Patient Information

Completed ☐

First Name_____ Last Name_____ DOB_____ SSN#_____

☐ Female ☐ Male Height _____ in **Weight_____lbs** Pregnant? (Y/N) _____ Alcohol Use? (Y/N) _____ Tobacco Use? (Y/N) _____

Address_____ City_____ State_____ ZIP_____

Cell Phone_____ Home Phone_____ Email_____

Prescription Information

Completed ☐

	Medication	*Strength*	*Sig (Directions for Use)*	*Qty*	*Refills*
☐	**Kevzara®** *(sarilumab)*	☐ 150mg/1.14mL Pre-Filled Syr (2) ☐ 200mg/1.14mL Pre-Filled Syr (2)	☐ Inject 150mg (1.14mL) SC every TWO weeks as directed by physician. Store in fridge ☐ Inject 200mg (1.14mL) SC every TWO weeks as directed by physican. Store in fridge ☐ Other: _____		
☐	**Orencia®** *(abatacept)*	☐ 250mg (IV) Lyophilized Pwdr SDV ☐ 125mg/mL Pre-Filled Syr (4 x 1mL) ☐ 125mg/mL Clickject Autoinjector (4) ****Patient Weight Required****	☐ **For Office (IV) Infusion** - After the initial dose, Orencia IV should be administered at 2 and 4 weeks, then every 4 weeks thereafter. ☐ Inject 1mL (125mg) SC once weekly as directed by physician. ☐ Other: _____		
☐	**Otezla®** *(apremilast)*	☐ 28 Day Titration Starter Pack	☐ Follow normal titration dosing schedule on starter pack. ☐ Other: _____		
		☐ 30mg Tablet	☐ Other: _____ ☐ Take 1 tablet by mouth _____ times daily as directed by physician.		
☐	**Simponi®** *(golimumab)*	☐ **50mg/0.5mL** ☐ Pre-Filled Syr ☐ AutoInjector	☐ Inject 50mg (0.5mL) SC once a month as directed by physician. ☐ Other: _____		
☐	**Stelara®** *(ustekinumab)*	☐ 45mg/0.5mL Pre-Filled Syr ☐ 90mg/mL Pre-Filled Syr	☐ Inject 45mg (0.5mL) SC , then 4 weeks later, followed by 45mg (0.5mL) every 12 weeks ☐ Inject 90mg (1mL) SC, then 4 weeks later, followed by 90mg (1mL) every 12 weeks. ☐ Other: _____		
☐	**Xeljanz® & Xeljanz® XR** *(tofacitinib)*	☐ 5mg Tablet ☐ 11mg Tablet *(XR)*	☐ Take 1 tablet by mouth TWO times daily as directed by physician. ☐ Take 1 tablet by mouth ONCE daily as directed by physician. ☐ Other: _____		

Diagnosis / Clinical Information *(provide patient clinicals and labs to expedite a Prior Auth)*

ICD-10 Code (Diagnoses) _____ _____ _____ _____ _____ _____

TB Test Date:_____ Negative? ☐ **If Positive** ☐ **Provide Date of Treatment** _____

Step Therapy (Has pt tried & failed previous meds?) If so, which ones & when? _____

_____

Drug Allergies _____

Drug Sensitivities _____

Current Medications _____

Current OTC/Vitamins _____

Recent Hospital Stay or Surgery? (Y/N) _____ If yes, provide details:_____

Insurance Information

Completed ☐

Insurance _____

ID _____

BIN _____

PCN _____

Group _____

Secondary? _____