

For assistance, contact your pharmacy representative: _____ Phone: _____ (For providers only)

PLEASE CONSIDER SENDING YOUR PRESCRIPTION ELECTRONICALLY. ALL OF OUR PHARMACY LOCATIONS ACCEPT ELECTRONIC PRESCRIPTIONS.

Note: This form is intended for prescriber use only, if faxed, the fax must come from MD office or hospital (may not be faxed by patient).

Pharmacy: _____ Pharmacy Fax: _____ Pharmacy Phone: _____
Date Needed: _____ Ship To: Prescriber's Office Patient's Home Other: _____

PATIENT INFORMATION

Patient name: _____ DOB: _____ Male Female
Address: _____ City: _____ State: _____ Zip code: _____
Phone # (Daytime): _____ Phone # (Evening): _____
E-mail Address: _____ Case Manager: _____
Insurance provider (Please include copy of front and back of card): _____
ID #: _____ Policy/Group #: _____ Phone #: _____ Patient is eligible for Medicare
Name of Insured: _____ Employer: _____
Relationship to Patient: Self Other: _____ Prescription Card: Yes No Carrier: _____ Policy/Group #: _____
Will there be access to anaphylactic medications and oxygen at the administration site? _____

CLINICAL ASSESSMENT – Please complete ALL sections to avoid delays in filling prescription

Patient is new to therapy Patient is currently on therapy Start date: _____ Physician Provides Injection Training Injection/Infusion Date: _____
Primary Diagnosis Code and Condition (ICD-10): _____ Other Diagnosis/Conditions: _____
Joints Affected: _____ Number of Tender Joints: _____ Number of Swollen Joints: _____ Current Weight: _____ Date: _____
 New Therapy Induction Therapy Change Therapy Continuation | Weeks Completed 0 2 4 6 | Stop Date: _____
ESR: _____ Date: _____ CRP: _____ Date: _____ TB Results: _____ Date: _____
Allergies: _____

MEDICATION

Actemra (tocilizumab)
 162mg Syringe Autoinjector
 80mg/4mL Vial
 200mg/10mL Vial
 400mg/20mL Vial
Directions: _____ Quantity: _____ Refills: _____
Benlysta (belimumab)
 200mg Syringe Autoinjector
 120mg vial
 400mg vial
Directions: _____ Quantity: _____ Refills: _____
Cimzia (certolizumab pegol)
 (6) 200mg starter kit
Directions: _____ Quantity: _____ Refills: _____
 (2) 200mg Syringe Vial
Directions: _____ Quantity: _____ Refills: _____
Cosentyx (secukinumab)
 150mg Pen Prefilled Syringe
 2X150mg Pack (300mg) Pen Prefilled Syringe
Directions: _____ Quantity: _____ Refills: _____
Enbrel (etanercept)
 25mg Syringe Vial
 50mg Syringe SureClick™ Pen Mini™ Cartridge
Directions: _____ Quantity: _____ Refills: _____
Humira (adalimumab)
 10mg/0.2ml Prefilled Syringe Pediatric
 20mg/0.4ml Prefilled Syringe Pediatric
 40mg/0.8ml Pen Prefilled Syringe
Directions: _____ Quantity: _____ Refills: _____
Humira citrate free (adalimumab)
 10mg/0.1ml citrate free Prefilled Syringe Pediatric
 20mg/0.2ml citrate free Prefilled Syringe Pediatric
 40mg/0.4ml citrate free Pen Prefilled Syringe
 80mg/0.8ml citrate free Pens
Directions: _____ Quantity: _____ Refills: _____

Inflectra (infliximab-dyyb)
 100mg Vial
Directions: _____ Quantity: _____ Refills: _____
Kezvara (sarilumab)
 150mg Syringe Pre-filled Pen
 200mg Syringe Pre-filled Pen
Directions: _____ Quantity: _____ Refills: _____
Olumiant
 2mg Tablets
Directions: _____ Quantity: _____ Refills: _____
Orencia (abatacept)
 50mg Prefilled Syringe
 87.5mg Prefilled Syringe
 125mg Clickject Pen Prefilled Syringe
 250mg Vial
Directions: _____ Quantity: _____ Refills: _____
Otezla (apremilast)
 Titration Pack
 30mg Tablets
Directions: _____ Quantity: _____ Refills: _____
Remicade (infliximab)
 100mg Vial
Directions: _____ Quantity: _____ Refills: _____
Renflexis (infliximab-abda)
 100mg vial
Directions: _____ Quantity: _____ Refills: _____
Rinvoq (upadacitinib)
 15mg Tablet
Directions: _____ Quantity: _____ Refills: _____
Rituxan (rituximab)
 100mg Vial
 500mg Vial
Directions: _____ Quantity: _____ Refills: _____
Simponi (golimumab)
 50mg Syringe Smartject
Directions: _____ Quantity: _____ Refills: _____

Simponi Aria (golimumab)
 50mg Vial
Directions: _____ Quantity: _____ Refills: _____
Skyrizi (risankizumab-rzaa)
 150mg Pen
 150mg Prefilled Syringe
Directions: _____ Quantity: _____ Refills: _____
Stelara (ustekinumab)
 45mg Prefilled Syringe Single-dose Vial
 90mg Prefilled Syringe
Directions: _____ Quantity: _____ Refills: _____
Taltz (ixekizumab)
 80mg Prefilled Syringe Autoinjector
Directions: _____ Quantity: _____ Refills: _____
Tremfya (guselkumab)
 100mg/ml
 One-Press Patient-Controlled Injector Prefilled Syringe
Directions: _____ Quantity: _____ Refills: _____
Xeljanz (tofacitinib)
 1mg/ml Oral Solution
 5mg Tablet
Directions: _____ Quantity: _____ Refills: _____
Xeljanz XR (tofacitinib)
 11mg Tablet
Directions: _____ Quantity: _____ Refills: _____
Other

Directions: _____ Quantity: _____ Refills: _____
Other

Directions: _____ Quantity: _____ Refills: _____
Methotrexate – Can only be ordered with other specialty meds.
 2.5mg Tablet
Directions: _____ Quantity: _____ Refills: _____

I authorize, by my signature below, the dispensing of appropriate needles and syringes, in a sufficient quantity, required for the administration of injectable products by patient or caregiver. Authorization for supplies runs concurrently with the number of refills or time frame specified for the drug.

PRESCRIBER INFORMATION

Prescriber's name: _____ Practice/facility: _____
Address: _____ City: _____ State: _____ Zip code: _____
Office contact: _____ Phone: _____ Fax: _____
Email: _____ Best time to call: _____ Preferred method of contact: Email Phone Fax
State license #: _____ DEA #: _____ NPI #: _____ Medicaid UPIN #: _____

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary" or your state specific required language after their signature. I certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge. Prescriber's signature required on one of the lines below.