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)**.

Rheumatoid Arthritis

Prescription/Pharmacy Intake Form

☐Central Pharmacy: ________________

☐Retail/Community 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	Dose/Directions/Frequency	Quantity	Refills
Actemra (tocilizumab) ☐162mg Syringe ☐80mg/4mL Vial ☐200mg/10mL Vial ☐400mg/20mL Vial			
Cimzia (certolizumab pegol) ☐(6) 200mg starter kit ☐(2) 200mg Syringe ☐(2) 200mg Vial			
Enbrel (etanercept) ☐25mg Syringe ☐25mg Vial ☐50mg Syringe ☐50mg SureClick™ Pen ☐50mg Mini™ Cartridge			
Humira (adalimumab) ☐10mg Syringe ☐20mg Syringe ☐40mg Syringe ☐40mg Pen			
Kevzara (sarilumab) ☐150mg Syringe ☐200mg Syringe			
Orencia (abatacept) ☐50mg Prefilled Syringe ☐87.5mg Prefilled Syringe ☐125mg Clickject Pen ☐125mg Prefilled Syringe ☐250mg Vial			
Inflectra (infliximab-dyyb) ☐100mg Vial			
Remicade (infliximab) ☐100mg Vial			
Rituxan (rituximab) ☐100mg Vial ☐500mg Vial			
Simponi (golimumab) ☐50mg Syringe ☐50mg Smartject **Simponi Aria (golimumab)** ☐50mg Vial			
Xeljanz (tofacitinib) ☐5mg Tablet **Xeljanz XR (tofacitinib)** ☐11mg Tablet			
Methotrexate – Can only be ordered as combined therapy with one of the above drugs. ☐2.5mg Tablet			
Other ☐ ________________			

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.

________________ Dispense as written ________________ Substitution permitted ________ Date

The prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.

The document(s) accompanying this transmission may contain confidential health information that is legally protected. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless permitted or required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.

Drug names are the property of their respective owners.

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