

PATIENT INFORMATION:

Patient's Name: _____
 Address: _____
 City, State, Zip Code: _____
 Home Phone: _____
 Alternate Phone: _____
 DOB: _____
 Last 4 Digits of SS#: _____
 Gender: _____
 Language Preference: _____

PRESCRIBER INFORMATION:

Prescriber's Name: _____
 DEA: _____
 NPI: _____
 Address: _____
 City, State, Zip Code: _____
 Phone: _____
 Fax: _____
 Contact Person: _____
 Contact Person's Phone: _____

INSURANCE INFORMATION: (please include copy of front and back of patient's prescription insurance card)

Prior Authorization Reference #: _____

MEDICAL INFORMATION: (may attach separate sheet if needed)
Diagnosis: Please include diagnosis and ICD-10 code

- M06.9 Rheumatoid arthritis, unspecified
 - M08.00 Unspecified juvenile rheumatoid arthritis of unspecified site
 - M08.3 Juvenile rheumatoid polyarthritis (seronegative)
 - M45.9 Ankylosing spondylitis of unspecified sites in spine
 - L40.59 Other psoriatic arthropathy
- Other Diagnosis: _____
 ICD-10 Code: _____
 Description: _____

Additional information:

Therapy: New Reauthorization Restart
 Weight: _____ kg/lb Height _____ cm/in
 Allergies: _____
 Lab Data: _____
 Prior Therapies: _____
 Concomitant Medications: _____
 Injection Training Required: Yes No
 Has a TB test been performed? Yes No
 Does the patient have an active infection? Yes No
 Date of Diagnosis: _____ Start Date: _____ Review Date: _____

PRESCRIPTION INFORMATION

Medication	Dose	Directions	Quantity	Refills
Benlysta®	<input type="checkbox"/> 120 mg Vial <input type="checkbox"/> 400 mg Vial <input type="checkbox"/> 200 mg/mL Autoinjector <input type="checkbox"/> 200mg/mL Prefilled Syringe			
Cimzia®	<input type="checkbox"/> 200 mg/mL Prefilled Syringe Starter Kit <input type="checkbox"/> 200 mg/mL Prefilled Syringe <input type="checkbox"/> 200 mg/mL Vial Kit			
Enbrel®	<input type="checkbox"/> 50 mg/mL SureClick Autoinjector <input type="checkbox"/> 50 mg/mL Prefilled Syringe <input type="checkbox"/> 25 mg/0.5 mL Prefilled Syringe <input type="checkbox"/> 25 mg Vial <input type="checkbox"/> Enbrel Mini 50 mg/mL Cartridge			
Humira®	<input type="checkbox"/> 10 mg/0.2 mL Prefilled Syringe <input type="checkbox"/> 10 mg/0.1 mL Prefilled Syringe <input type="checkbox"/> 20 mg/0.4 mL Prefilled Syringe <input type="checkbox"/> 20 mg/0.2 mL Prefilled Syringe <input type="checkbox"/> 40 mg/0.4 mL Prefilled Syringe <input type="checkbox"/> 40 mg/0.8 mL Prefilled Syringe <input type="checkbox"/> 40 mg/0.4 mL Pen <input type="checkbox"/> 40 mg/0.8 mL Pen			
Orencia®	<input type="checkbox"/> 250 mg Vial <input type="checkbox"/> 87.5 mg/0.7 mL Prefilled Syringe <input type="checkbox"/> 125 mg/mL Prefilled Syringe <input type="checkbox"/> 125 mg/mL ClickJect Autoinjector <input type="checkbox"/> 50 mg/0.4mL Prefilled Syringe			
Otezla®	<input type="checkbox"/> 30 mg Tablet <input type="checkbox"/> Starter Pack (28-day) <input type="checkbox"/> Starter Pack (2-week)			
Remicade®	<input type="checkbox"/> 100 mg Vial			
Simponi®	<input type="checkbox"/> 50 mg/0.5 mL Prefilled Syringe <input type="checkbox"/> 50 mg/0.5 mL SmartJect Autoinjector			
Simponi Aria®	<input type="checkbox"/> 50 mg/4m mL Vial			
Stelara®	<input type="checkbox"/> 45 mg/0.5 mL Vial <input type="checkbox"/> 45 mg/0.5 mL Prefilled Syringe <input type="checkbox"/> 90 mg/mL Prefilled Syringe			
Taltz®	<input type="checkbox"/> 80 mg/mL Autoinjector <input type="checkbox"/> 80 mg/mL Prefilled Syringe			
Xeljanz®	<input type="checkbox"/> 5 mg Tablet			
Xeljanz XR®	<input type="checkbox"/> 11 mg ER Tablet			
OTHER: _____				

Please deliver to: Patient Office Other _____ by this date: _____

Prescriber Authorization: I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

Product Substitution Permitted Dispense as Written

Prescriber's Signature: _____

CONFIDENTIALITY STATEMENT: This communication is intended for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential, and exempt from disclosure under applicable law. If the reader of this communication is not the intended recipient or the employee or agent responsible for delivery of the communication, you are hereby notified that any dissemination, distribution, or copying of the communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone.