

Date Required: \_\_\_\_\_ Ship To:  Home  Office  Other: \_\_\_\_\_

**PATIENT INFORMATION**

Patient Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_  
 Cell Phone: \_\_\_\_\_  
 Alternate Phone: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_

**PRESCRIBER INFORMATION**

Prescriber Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_  
 Fax: \_\_\_\_\_  
 DEA #: \_\_\_\_\_ NPI #: \_\_\_\_\_  
 Contact Person: \_\_\_\_\_

**INSURANCE INFORMATION (Please attach the front and back of insurance and prescription drug card.)**

Primary Insurance: \_\_\_\_\_ ID: \_\_\_\_\_ Group: \_\_\_\_\_  
 Secondary Insurance: \_\_\_\_\_ ID: \_\_\_\_\_ Group: \_\_\_\_\_  
 Prescription Card: \_\_\_\_\_ ID: \_\_\_\_\_ BIN: \_\_\_\_\_ PCN: \_\_\_\_\_

**To better serve your patient and facilitate insurance authorization, please complete the pertinent sections:**

**DIAGNOSIS/CLINICAL INFORMATION**

M06.9 Rheumatoid Arthritis  
 M45.9 Ankylosing Spondylitis  
 M32.10 Systemic Lupus Erythematosus  
 K50.00 Crohn's Disease  
 L40.50 Psoriatic Arthritis  
 Other: \_\_\_\_\_

Prior Medication Failed: \_\_\_\_\_  
 Length of Treatment: \_\_\_\_\_  
 Reason for Discontinuation: \_\_\_\_\_

Methotrexate Failed Length of Treatment: \_\_\_\_\_ Reason for Discontinuation: \_\_\_\_\_

TB/PPD test:  Positive  Negative  Date Read: \_\_\_\_\_  
 Forteo T-score: \_\_\_\_\_ Type: \_\_\_\_\_ Date: \_\_\_\_\_ Site: \_\_\_\_\_  
 Fractured: \_\_\_\_\_ Date: \_\_\_\_\_  
 Forteo® Home Health Training Required  
 Humira® or Enbrel® home health training required  
 Patient Weight: \_\_\_\_\_  kg  lbs Height: \_\_\_\_\_  cm  in  
 Allergies: \_\_\_\_\_  
 Lab Data: \_\_\_\_\_

**PRESCRIPTION INFORMATION**

Medication:	Dose/Strength:	Directions:	Quantity:	Refills:
<input type="checkbox"/> Actemra®	<input type="checkbox"/> 162mg PFS	<input type="checkbox"/> Inject 162mg every other week (under 100kg) <input type="checkbox"/> Inject 162mg every week (over 100kg)	1 month supply	
<input type="checkbox"/> Benlysta®	<input type="checkbox"/> 200mg Autoinjector <input type="checkbox"/> 200mg PFS	<input type="checkbox"/> Inject 200mg subcutaneously ONCE a week	4 week supply	
<input type="checkbox"/> Cimzia®	<input type="checkbox"/> 200mg X2 PFS	<input type="checkbox"/> Inject 400mg SC at weeks 0, 2, and 4 <input type="checkbox"/> Inject 400mg once monthly <input type="checkbox"/> Inject 200mg every other week	1 month supply	
<input type="checkbox"/> Cosentyx®	<input type="checkbox"/> 300mg (2x150) Pen <input type="checkbox"/> PFS <input type="checkbox"/> 150mg Pen <input type="checkbox"/> PFS  *Covered Until You're Covered	<input type="checkbox"/> Load: Inject <input type="checkbox"/> 300mg or <input type="checkbox"/> 150mg SC week 0,1,2,3,4 <input type="checkbox"/> Maintenance: Inject <input type="checkbox"/> 300mg or <input type="checkbox"/> 150mg SC every 4 weeks <input type="checkbox"/> Free Drug Load: Inject <input type="checkbox"/> 300mg or <input type="checkbox"/> 150mg SC week 0,1,2,3,4* <input type="checkbox"/> Free Drug Maintenance: Inject <input type="checkbox"/> 300mg or <input type="checkbox"/> 150 mg SC every 4 weeks*	5 week supply 4 week supply 5 week supply 4 week supply	
<input type="checkbox"/> Enbrel®	<input type="checkbox"/> 50mg Sureclick <input type="checkbox"/> 25mg Vials <input type="checkbox"/> 50mg PFS <input type="checkbox"/> 25mg PFS <input type="checkbox"/> Mini™ with Autotouch™	<input type="checkbox"/> Inject 50mg once weekly <input type="checkbox"/> Inject 50mg twice weekly <input type="checkbox"/> Inject 25mg once weekly <input type="checkbox"/> Inject 25mg twice weekly	1 month supply	
<input type="checkbox"/> Forteo®	<input type="checkbox"/> 750µg/3ml pen and supplies	<input type="checkbox"/> Inject 20 µg SC once daily	1 month supply	
<input type="checkbox"/> Humira®	<input type="checkbox"/> 40mg Pen <input type="checkbox"/> 40mg PFS	<input type="checkbox"/> Inject 40mg SC once a week <input type="checkbox"/> Inject 40mg SC every other week	1 month supply	
<input type="checkbox"/> Kevzara®	<input type="checkbox"/> 150mg PFS <input type="checkbox"/> 200mg PFS	<input type="checkbox"/> Inject one PFS SC every 2 weeks	1 month supply	
<input type="checkbox"/> Methotrexate	<input type="checkbox"/> 2.5mg tab <input type="checkbox"/> 25mg/ml vial	<input type="checkbox"/> Take _____mg by mouth once weekly <input type="checkbox"/> Inject _____mg SC once weekly	1 month supply	
<input type="checkbox"/> Orencia®	<input type="checkbox"/> 125mg PFS <input type="checkbox"/> 250mg Vial	<input type="checkbox"/> Inject 125mg once weekly <input type="checkbox"/> Inject _____mg once monthly	1 month supply	
<input type="checkbox"/> Otezla®	<input type="checkbox"/> 30mg tablet <input type="checkbox"/> Starter Pack	<input type="checkbox"/> Take 1 tablet by mouth twice daily <input type="checkbox"/> Take as per package instructions	1 month supply	
<input type="checkbox"/> Otrexup®	<input type="checkbox"/> _____mg/0.4ml	<input type="checkbox"/> Inject _____mg once weekly	1 month supply	
<input type="checkbox"/> Rasuvo®	<input type="checkbox"/> _____mg	<input type="checkbox"/> Inject _____mg once weekly	1 month supply	
<input type="checkbox"/> Simponi®	<input type="checkbox"/> 50mg Smartject <input type="checkbox"/> 50mg PFS	<input type="checkbox"/> Inject 50mg SC once monthly	1 month supply	
<input type="checkbox"/> Stelara®	<input type="checkbox"/> 45mg PFS <input type="checkbox"/> 90mg PFS	<input type="checkbox"/> Inject 45mg day 1 and week 4, then inject 45 every 12 weeks <input type="checkbox"/> Inject 90mg day 1 and week, then inject 90mg every 12 weeks	1 month supply	
<input type="checkbox"/> Xeljanz®	<input type="checkbox"/> 5mg tablet <input type="checkbox"/> XR 11mg tablet	<input type="checkbox"/> Take 1 tablet by mouth twice daily <input type="checkbox"/> Take 1 tablet by mouth once daily	1 month supply	
<input type="checkbox"/> Other:				

Prescriber Signature: \_\_\_\_\_ Date: \_\_\_\_\_ UPIN: \_\_\_\_\_