

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: _____

The information contained in this facsimile may be confidential and is intended solely for the use of the named recipient(s). Access, copying or re-use of the facsimile or any information contained therein by any other person is not authorized. If you are not the intended recipient, please notify us immediately by faxing back to the originator.