Rep Code: AANY100

PHARMACY

FAX: **888-865-8954**

↓ Must Be Filled Out ↓

❑ New Patient ❑ Current

Patient's Name _____

D.O.B. _____ ❑ Male ❑ Female Last 4 digits of SSN _____

Street Address _____ Apt # _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

E-mail Address _____

Insurance Company _____

Insured's Name _____

Relationship to Patient _____

Does patient have a secondary insurance? ❑ Yes ❑ No

Date _____

Date Medication Needed: _____

Prescriber's Name and Title _____

Street Address _____ Suite # ___

City _____ State ____ Zip _____

Phone _____ Fax _____

NPI # _____

DEA # _____

Allergies: _____

In order to dispense brand, BRAND MEDICALLY NECESSARY must be *handwritten* here:

_____

Diagnosis/Clinical Information

Diagnosis: _____ ❑ Other: _____

Prior failed medication (medication and duration of treatment/reason for d/c):

❑ _____

❑ _____

Is patient currently on RA therapy? Yes No

Medications: _____

TB/PPD Test Given? Yes No

BMD/T-score: _____ **Date:** _____

Does patient have a latex allergy? Yes No

Is patient at risk for osteoporotic fracture as evident by any of the following?

❑ History of osteoporotic fracture Site: _____ Date: _____

❑ Patient has tried and failed an oral bisphosphonate

❑ Patient has documented contraindiction/is intolerant to oral bisphosphonate therapy (please submit a copy of DEXA w/prescription)

Prescription Information

Medication	Dose/Strength	Sig	Qty	Refills
❑ **Actemra®**	❑ 162mg/0.9ml PFS	❑ Inject 1 syringe SC every week ❑ Inject 1 syringe SC every other week	4 week supply	
❑ **Cimzia®** Initial Dose	200mg Starter Kit (contains 6, 200mg PFS)	Inject 400mg SC once, then repeat at weeks 2 and 4	4 week supply	No refills
❑ **Cimzia®** Maintenance Treatment	2 x 200mg Prefilled Syringe	❑ 200mg SC ONCE every TWO weeks ❑ 400mg SC ONCE every FOUR weeks	4 week supply	
❑ **Diclofenac 3%, Lidocaine 5%**	❑ Apply 1-2 pumps (1.5g per pump) 3-4 times a day as needed			
❑ **Enbrel®**	❑ 50mg/ml SureClick™ Autoinjector ❑ 50mg/ml Prefilled Syringe ❑ 25mg/0.5ml Prefilled Syringe	❑ Inject 50mg SC ONCE a week ❑ Inject 25mg TWICE a week, 72 to 96 hours apart ❑ **Other:**	4 week supply	
❑ **Forteo®** ❑ **Pen Needles** (28 needles)	❑ 600mcg/2.4ml PFS ❑ 31 gauge 6mm	❑ Inject 20mcg SC, as directed once daily	4 week supply	
❑ **Humira®** ❑ Injection training from My Humira	❑ 40mg/0.8ml Pen ❑ 40mg/0.8ml Prefilled Syringe	❑ Inject 40mg SC every OTHER week ❑ Inject 40mg SC ONCE a week	4 week supply	
❑ **Orencia®**	❑ 125mg/ml Prefilled Syringe (4 syringes)	❑ Inject 125mg SC ONCE weekly	_____	
❑ **Otezla®**	❑ 30mg Tablets	❑ Take 30mg tablet twice a day		
❑ **Otrexup®**				
❑ **Prolia®**	❑ 60mg Prefilled Syringe	❑ Inject 60mg SC ONCE every 6 months		
❑ **Rasuvo®**				
❑ **Remicade®**				
❑ **Simponi®**	❑ 50mg/0.5ml Prefilled Syringe ❑ 50mg/0.5ml Autoinjector	❑ Inject 50mg ONCE a month	4 week supply	
❑ **Xeljanz®**	❑ 5mg Tablets	❑ Take 5mg by mouth Q.D.		

Physician Office Contact: Name: _____ Email: _____

Phone: _____ Fax: _____

Physician Signature: