Rheumatology Prescription Form
Please complete the form and fax to: 804-628-1533
Pharmacy Phone Number: 1-877-814-3475

Patient Information			Prescriber Information			
Patient Name:			Physician Name:		Practice/Organization Name:	
Date of Birth:	Gender: ☐ Male ☐ Female		Address:			
Address:			City:	State:	Zip Code:	
City:	State:	Zip Code:	Phone#:		Fax#:	
Home Phone:	Work Phone:		DEA:	NPI:	License:	Medicaid UPIN:
Cell Phone:	Email:		Physician Specialty:			
Insurance Information			Date Shipment Needed:	Ship to: ☐ Patient ☐ Prescriber ☐ Infusion Clinic		
ID#:			Shipment Address:			
Group#:	RxBIN:	RxPCN:	City:	State:	Zip Code:	

If shipped to the physician's office, physician accepts on behalf of patient for administration in office.

Clinical Information and Prescription

Diagnosis and Clinical Information:

☐ M06.9 Rheumatoid Arthritis ☐ M45.9 Ankylosing Spondylitis ☐ L40.59 Psoriatic Arthritis ☐ M08.01 Juvenile Chronic Polyarthritis ☐ Other: _____

Date of Diagnosis or Years with Disease: _____ Patient Allergies: _____ Patient Weight: _____kg/lbs Patient Height: _____cm/in

Has the patient had a **negative** tuberculin skin test? ☐ Yes ☐ No | Is the patient a carrier of the Hepatitis B virus? ☐ Yes ☐ No | Latex allergy? ☐ Yes ☐ No

Injection training needed? ☐ Yes ☐ No

Prior DMARD's and length of treatment:_____ Prior DMARD's and length of treatment Expected First Dose Date:_____

☐ **Actemra** (tocilizumab) ☐ Inject 162mg SC every week (>/=100kg) ☐ Inject 162 mg SC every other week (<100kg)	☐ **Cimzia** (certolizumab pegol) Initial Dose: ☐ 400mg SC @ 0,2,4 weeks prefilled syringe OR ☐ 400mg SC @ 0,2,4 weeks lyophilized powder vial (in office) Maintenance Dose: ☐ 400mg SC every 4 weeks ☐ 200mg SC every 2 weeks ☐ Prefilled Syringe OR ☐ Vial	☐ **Enbrel** (etanercept) Dose: ☐ 50mg SureClick ☐ 50mg Prefilled Syringe ☐ 25mg Prefilled Syringe ☐ 25mg Vial Dispense: ☐ Inject SC once per week ☐ Inject SC once per week ☐ (JIA) Inject 0.8mg/kg, max 50mg/week
☐ **Humira** (adalimumab) Dose: ☐ 40mg Pen Auto Injector ☐ 40mg Prefilled Syringe ☐ 20mg Prefilled Syringe ☐ 10mg Prefilled Syringe ☐ Citrate/buffer free formulation Dispense: ☐ Inject SC once every other week ☐ Inject SC once per week ☐ Other:_____	☐ **Kevzara** (sarilumab) Inject SC once every 2 weeks Dose: ☐ 150mg/1.14ml ☐ 200mg/1.14ml ☐ Prefilled Syringe OR ☐ Prefilled Pen	☐ **Olumiant** (baricitinib) 2mg PO once daily
☐ **Orencia** (abatacept) ☐ Inject 125mg Prefilled Syringe SC once weekly	☐ **Simponi** (golimumab) Inject SC once per month ☐ 50mg SmartJect OR ☐ 50mg prefilled syringe	☐ **Xeljanz** (tofacitinb) 5mg PO twice daily ☐ **Xeljanz XR** (tofacitinb) 11mg PO once daily

Quantity Prescribed: ☐ QS 30 days ☐ Other: _____ **Refills Authorized:** ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 6 ☐ 1yr ☐ Other:_____

Physician Signature (no stamps): _____ **Date:**_____

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