Star Discount Pharmacy specialty care

Rheumatoid Arthritis

Call: (877) 883-1392 Fax: (256) 429-2221

Patient Information: Name: _____ DOB: _____ Gender: ○M ○F Last 4 of SSN:
Address: _____ City: _____ State: ____ Zip: _____ Phone: _____ Alt. Phone: _____
Email: _____ Ht: ____ Wt: ____ Care Giver: _____ Allergies: ○No Known ○See Attached Charts

Prescriber Information: Name: _____ Address: _____ City: _____
State: _____ Zip: _____ NPI: _____ Phone: _____ Fax: _____ Office Contact: _____

Statement of Medical Necessity (Please Attach All Medical Documentation)

Date of Diagnosis: _____ **ICD-10:**_____ **Other:** _____ **TB Test:** ○ Positive ○ Negative Date: _____

Patient also taking Methotrexate? ○**Yes** ○**No**
Serious or active infection present? ○**Yes** ○**No**
Hep B ruled out or treatment started? ○**Yes** ○**No**
Does patient have latex allergy? ○**Yes** ○**No**

LFT: AST: _____ ALT: _____ Date: _____

Injection Training: ○Pharmacist to Provide Training
○Patient Trained in MD Office ○Manufacturer Nurse Support

Product Delivery: ○Patient's Home ○Physician's Office
○Pharmacy to Coordinate

Prior Failed Treatments	Drug Name and Length of Treatment
○Azulfidine	
○Biologics	
○Calcipotriene	
○Celebrex	
○Corticosteroids	
○Indocin	
○Methotrexate	
○Other	

Prescription Information

Medication	Dosage & Strength	Directions	Qty	Refills
○Actemra	○ 162mg/0.9ml Prefilled Syringe ○ 162mg/0.9ml Prefilled Autoinjector	○ **<220lb:** Inject 162mg SC every other week, followed by an increase to every week based on clinical response ○ **>220lb:** Inject 162mg SC every week		
○Cimzia	○ Prefilled Syringe Starter Kit ○ 200mg/ml Prefilled Syringe ○ 200mg Lyophilized Powder Vial	○ **Induction Dose**: Inject 400mg SC on day 1, 14, and 28	6	0
		○ **Maintenance**: Inject 400mg SC every 4 weeks	2	
		○ **Maintenance**: Inject 200mg SC every other week		
○Colcigel	○	○		
○Cosentyx	○ 150mg/ml Sensoready Pen ○ 150mg/ml Prefilled Syringe ○ 150mg/ml Lyophilized Powder Vial	○ **Induction Dose:** Inject 150mg SC at weeks 0, 1, 2, 3, 4	5	0
		○ **Induction Dose:** Inject 300mg SC at weeks 0, 1, 2, 3, 4	10	0
		○ **Maintenance:** Inject 150mg SC every 4 weeks	1	
		○ **Maintenance:** Inject 300mg SC every 4 weeks	2	
○Enbrel	○ 50mg/ml SureClick Autoinjector ○ 50mg/ml Enbrel Mini Prefilled Cartridge *For Enbrel Mini Only: AutoTouch Autoinjector* ○ 50mg/ml Prefilled Syringe ○ 25mg/0.5ml Prefilled Syringe ○ 25mg/ml Vial	○Inject 50mg SC once a week		
○Humira	○ 40mg/0.4ml Pen ○ 40mg/0.4ml Prefilled Syringe	○Inject 40mg SC every other week ○Patient has signed Humira ○Inject 40mg SC every week Complete Form ***All strengths and dosages are Humira Citrate Free***		
○Kevzara	○ 150mg/1.14ml Prefilled Syringe ○ 150mg/1.14ml Prefilled Pen ○ 200mg/1.14ml Prefilled Syringe ○ 200mg/1.14ml Prefilled Pen	○Inject 150mg SC every two weeks	2	
		○Inject 200mg SC every two weeks	2	
○Olumiant	○ 2mg Tablet ○ 1mg Tablet	○Take one 2mg tablet by mouth with or without food daily	30	
		○Moderate renal impairment: Take one 1mg tablet by mouth with or without food daily	30	
○Orencia	○ 125mg/ml Prefilled Syringe ○ 125mg/ml ClickjectTM Autoinjector ○ 250mg Lyophilized Powder Vial	**Induction Dose:** ○<60kg: 500mg administered IV, then inject 125mg SC within 24h ○60-100kg: 750mg administered IV, then inject 125mg SC within 24h ○>100kg: 1,000mg administered IV, then inject 125mg SC within 24h		
		○Inject 125mg SC once a week		
☐	○	○		

Prescriber Signature (I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs)

Signature: _____ Signature_____ Date: _____

Substitution Permitted **Dispense as Written**

Prior authorization approval and insurance benefits will be determined by the payor based upon the patient's eligibility, medical necessity, and the terms of the patient's coverage, among other things. Participation in this program is not a guarantee of prior authorization or of payment.