

Patient Information: Name: _____ DOB: _____ Gender: M F
 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
<input type="radio"/> Azulfidine	
<input type="radio"/> Biologics	
<input type="radio"/> Calcipotriene	
<input type="radio"/> Celebrex	
<input type="radio"/> Corticosteroids	
<input type="radio"/> Indocin	
<input type="radio"/> Methotrexate	
<input type="radio"/> Other	

Prescription Information

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

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.