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	Ref
○Otezla	○ Two-Week Starter Pack (Titration) ○ 28-Day Starter Pack (Titration) ○ 30mg Tablets	○ **Starter Pack**: Take one tab in the morning on Day 1, then take one tab in the morning and one tab in the evening as directed per pack	1	
		○ **Maintenance:** Take one 30mg Tablet by mouth twice daily *For patients with severe renal impairment take one 30mg tablet once daily and skip afternoon doses in starter pack.*	60	
○Rasuvo	○	○		
○Rinvoq	○ 15mg Extended Release Tablets	○ Take one 15mg Tablet once a day	30	
○Simponi	○ 50mg/0.5ml Smartject Autoinjector ○ 50mg/0.5ml Prefilled Syringe	○ Inject 50mg SC once a month	1	
○Stelara (for PsA)	○ 45mg/0.5ml Prefilled Syringe ○ 45mg/0.5ml Vial ○ 90mg/1ml Prefilled Syringe ○ **Stelara self-injection:** *Healthcare provider certifies that patient has been trained and is eligible for self-injection*	○ **Induction Dose**: Inject 45mg SC on day one	1	
		○ **Maintenance**: Inject 45mg SC on day 29, and every 12 wks thereafter	1	
		PsA with Coexistent Moderate to Severe Plaque Psoriasis (>220lb) ○ **Induction Dose**: Inject 90mg SC on day 1	1	
		○ **Maintenance**: Inject 90mg SC on day 29, and every 12 wks thereafter	1	
○Taltz	○ 80mg/ml Single-Dose Prefilled Autoinjector ○ 80mg/ml Single-Dose Prefilled Syringe	**Ankylosing Spondylitis** ○**Induction Dose**: Inject 160mg SC (two 80mg injections) at week 0	2	0
		○**Maintenance**: Inject 80mg SC every 4 weeks	1	
		Non-Radiographic Axial Spondyloarthritis ○Inject 80mg SC every 4 weeks	1	
		Psoriatic Arthritis: ○Induction Dose: Inject 160mg SC (two 80mg injections) at week 0	2	0
		○Maintenance: Inject 80mg SC every 4 weeks	1	
		PsA with Coexistent Moderate to Severe Plaque Psoriasis ○**Weeks 0-2**: Inject 160mg SC (two 80mg injections) at week 0, then inject 80mg at week 2	3	0
		○**Weeks 4-10**: Inject 80mg SC at week 4 and every 2 weeks thereafter through week 10	2	1
		○**Weeks 12 & Onward**: Inject 80mg SC at week 12 and every 4 weeks thereafter	1	
Tremfya	○ 100mg/ml Prefilled Syringe ○ 100mg/ml One-Press Patient Controlled Injector	○ **Induction Dose:** Inject 100mg SC at weeks 0 and 4	2	0
		○ **Maintenance:** Inject 100mg SC every 8 weeks thereafter	1	
Xeljanz Xeljanz XR	○ 5mg Tablet ○ 11mg Tablet	○ Take one 5mg tablet by mouth twice a day	60	
		○ Take on 11mg tablet by mouth once a day ***For patients with moderate renal or hepatic impairment take one 5mg tablet once daily***	30	

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.

Revised 10/15/2020

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Injection Training: ○Pharmacist to Provide Training
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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: _____

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