PREMIER PHARMACY SERVICES

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RHEUMATOLOGY RX ORDER FORM

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Ship to: ☐ Patient ☐ Physician ☐ Other • **Need:** ☐ Nurse ☐ Training
All supplies, including syringes and needles, will be dispensed if needed.

Patient Information

Patient Name: ______________________ DOB: __________ Address: ______________________

City: ______________________ State: __________ Zip: __________ Phone: ______________ Alt. Phone: __________

SS#: ____

Allergies: ______________________ Alternate Contact Info: ______________________

Clinical

Please attach copies of front and back of Patient's Prescription Insurance Cards and most recent labs.

Clinical:

Gender: ☐ M ☐ F

HT: __________

WT: __________

BSA: __________

DIAGNOSIS:

- ☐ **M06.9 Rheumatoid arthritis, unspecified**
- ☐ **M08.00 Unspecified juvenile rheumatoid arthritis of unspecified site**
- ☐ **M08.3 Juvenile rheumatoid polyarthritis (seronegative)**
- ☐ **M45.9 Ankylosing spondylitis of unspecified sites in spine**
- ☐ **L40.52 Psoriatic Arthritis**
- ☐ **Other Diagnosis: ICD-10 Code** __________________

Description __________________

Date of Diagnosis __________________

Has a TB test been performed? ☐ Yes ☐ No

Does the patient have an active infection? ☐ Yes ☐ No

Start Date __________________

Review Date __________________

Prescription

Prescription:	Dose / Strength	Directions	Qty.	Refills:
☐ **Actemra (Genentech** ☐ Enroll in ACTIV	☐ 80mg/4ml Vial ☐ 162mg/0.92ml Prefilled ? ☐ 200mg/10ml Vial ☐ 400mg/20ml Vial	☐ Inject 4mg/kg IV q 4 weeks		
☐ **Cimzia (UCB)** ☐ Enroll in CIMplicity	☐ 200mg/ml Starter Kit ☐ 200mg/10ml single use Prefilled Syringe	☐ **Initial dose:** Inject 400mg SQ initially, repeat dose on weeks 2 and 4 ☐ **Maintenance:** Inject 400mg SQ every 4 weeks		
☐ **Cosentyx**	☐ 150mg/ml Prefilled Syringe ☐ 150mg/ml Sensoready Pen	☐ **Initial dose:** 300mg SQ once weekly at weeks 0, 1, 2, 3, and 4 ☐ **Maintenance dose:** 300mg SQ every 4 weeks ☐ **Dosage adjustment -** some patients may only receive 150mg/dose		
☐ **Enbrel (Amgen)** ☐ Enroll in Enbrel Support	☐ 25mg/ml Vial ☐ 25mg/0.5ml Prefilled Syr ☐ 50mg/ml Prefilled Syr ☐ 50mg/ml SureClick Autoinjector	☐ Inject 50mg SQ weekly		
☐ **Humira (Abbott)** ☐ Enroll in HUMIRA COMPLETE	☐ 40mg/0.8 Prefilled AutoPen. ☐ 40mg/0.8ml Prefilled Syringe	☐ **Initial Dose:** Inject 40mg SQ every other week ☐ **Maintenance Dose:** Inject 40mg SQ every week if not on Methotrexate		
☐ **Orencia (BMS)** ☐ Enroll in The Circle	☐ 250mg Vial ☐ 125mg/ml single dose Prefilled Syr	☐ Please indicate dose: __________		
☐ **Otezla (Celgene)** ☐ Enroll in SupportPlus	☐ Starter Pak Tablet (28 days) ☐ 30mg Tablet	☐ **Initial titration dose:** 10mg qAM on day 1 then titrate upward by additional 10mg/day on days 2 to 5 ☐ **Maintenance dosage:** 30mg PO twice a day starting on day 6		
☐ **Remicade (Janssen)** ☐ Enroll in AccessOne	☐ 100mg/20ml Vial	For Ankylosing Spondylitis ☐ **Initial dose:** Inject 5mg/kg IV at week 0, 2, and 6 ☐ **Maintenance:** Inject 5mg/kg IV every 6 weeks thereafter For Psoriatic Arthritis ☐ **Initial dose:** Inject 5mg/kg IV at week 0, 2 ad 6 ☐ **Maintenance:** Inject 5mg/kg IV every 8 weeks thereafter For Rheumatoid Arthritis ☐ **Initial dose:** Inject 3mg/kg IV at week 0, 2, and 6 ☐ **Maintenance:** Inject 3mg/kg IV every 8 weeks thereafter		
☐ **Rituxan (Genentech)** ☐ Enroll in RISE	☐ 100mg/10ml Vial ☐ 500mg/50ml Vial	☐ Inject 1000mg IV on days 1 & 15 in combination with methotrexate		
☐ **Simponi (Janssen)** ☐ Enroll in SimponiOne	☐ 50mg/0.5ml Smartject Autoinjector ☐ 50mg/0.5ml Prefilled Syringe	☐ Inject 50mg SQ once per month		
☐ **Xeljanz (Pfizer)** ☐ Enroll in XELSOURCE	☐ 5mg Tablet	☐ Take 5mg PO twice a day		

☐ **Stelara®**	☐ Injection 45 mg/0.5mL in a single-use prefilled syringe ☐ Injection: 90 mg/mL in a single use prefilled syringe	☐ The recommended dose is 45 mg SQ initially and 4 weeks later, followed by 45 mg SQ every 12 weeks. For patients with co-existent moderate-to-severe plaque psoriasis weighing>100kg (220lbs), the recommended dose is 90 mg initially and 4 weeks later, followed by 90 mg every 12 weeks.		

Prescriber information

Prior Authorization:

Prescriber Name: ______________________ NPI: ____________ DEA: ________ LIC#: _______

Address: ____

City: _________________ Zip: __________ Tel: _______________ FAX: ______________

CONTACT PERSON: ____

I authorize Premier Pharmacy and it's representatives to act as an agent to initiate & execute prior authorization for above patient in order to expedite the process, please provide chart notes & most recent labs.

Physician's Signature: ______________________ ☐ **DAW (Dispense as Written)** **Date** ____ /____/____

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