

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

Patient Information	Patient Name: _____ DOB: _____ SSN: _____
	Address: _____ City: _____ State: _____ Zip: _____
	Phone: _____ Alt Phone: _____ Alternate Contact Info: _____
	Allergies: _____

PLEASE ATTACH COPIES OF FRONT AND BACK OF PATIENT'S PRESCRIPTION INSURANCE CARDS AND MOST RECENT LABS

Clinical	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female BSA: _____ Height: _____ Weight: _____	Diagnosis: <input type="checkbox"/> M06.9 Rheumatoid Arthritis, unspecified <input type="checkbox"/> M08.00 Unspecified Juvenile Rheumatoid Arthritis of unspecified site <input type="checkbox"/> M08.3 Juvenile Rheumatoid Polyarthritis (seronegative) <input type="checkbox"/> M45.9 Ankylosing Spondylitis of unspecified sites in spine <input type="checkbox"/> L40.52 Psoriatic Arthritis <input type="checkbox"/> Other Diagnosis: ICD-10 Code
	TB test given: <input type="checkbox"/> Yes <input type="checkbox"/> No Does patient have an active infection? <input type="checkbox"/> Yes <input type="checkbox"/> No	Description: _____
	Start Date: _____	Date of Diagnosis: _____
	Review Date: _____	

Prescription	Medication	Dose/Strength	Directions	Qty	Refills
<input type="checkbox"/>	Actemra	<input type="checkbox"/> 162mg/0.9ml Pen <input type="checkbox"/> 162mg/0.9ml Prefilled Syringe	For Rheumatoid Arthritis <input type="checkbox"/> Inject 162mg SQ every other week (<100kg) <input type="checkbox"/> Inject 162mg SQ weekly (≥100kg)	2 4	_____ _____
			For Polyarticular Juvenile Idiopathic Arthritis <input type="checkbox"/> Inject 162mg SQ every 3 weeks (<30kg) <input type="checkbox"/> Inject 162mg SQ every 2 weeks (≥30kg)	1 2	_____ _____
			For Systemic Juvenile Idiopathic Arthritis <input type="checkbox"/> Inject 162mg SQ every 2 weeks (<30kg) <input type="checkbox"/> Inject 162mg SQ every week (≥30kg)	2 4	_____ _____
<input type="checkbox"/>	Cimzia	<input type="checkbox"/> 200mg/ml Start Kit <input type="checkbox"/> 200mg/ml Single Use Prefilled Syringe	<input type="checkbox"/> Initial Dose: Inject 400mg SQ initially, then repeat dose at week 2 and 4 <input type="checkbox"/> Maintenance: Inject 400mg SQ every 4 weeks	6 syringes 2 syringes	None _____
<input type="checkbox"/>	Cosentyx	<input type="checkbox"/> 150mg/ml Prefilled Syringe <input type="checkbox"/> 150mg/ml Sensoready Pen <input type="checkbox"/> 150mg/ml (2 pack) PFS <input type="checkbox"/> 150mg/ml (2-pen pack) Sensoready Pen	<input type="checkbox"/> Initial Dose: Inject <input type="checkbox"/> 150mg or <input type="checkbox"/> 300mg SQ weekly at week 0, 1, 2, 3, and 4 <input type="checkbox"/> Maintenance: Inject <input type="checkbox"/> 150mg or <input type="checkbox"/> 300mg SQ every 4 weeks	5 week supply 4 week supply	None _____
<input type="checkbox"/>	Enbrel	<input type="checkbox"/> 50mg/ml Enbrel Mini-Cartridge <input type="checkbox"/> 50mg/ml Prefilled Syringe <input type="checkbox"/> 50mg/ml SureClick Autoinjector	<input type="checkbox"/> Inject 50mg SQ weekly	4	_____
<input type="checkbox"/>	Humira	<input type="checkbox"/> Citrate Free 40mg/0.4ml Pen <input type="checkbox"/> Citrate Free 40mg/0.4ml PFS	<input type="checkbox"/> Inject 40mg SQ every other week	2	_____
			<input type="checkbox"/> Alternate Dose: Inject 40mg SQ every week <input type="checkbox"/> Alternate Dose: Citrate Free 80mg/0.8ml Pen Inject 80mg SQ every other week	4 2	_____ _____
<input type="checkbox"/>	Kevzara	<input type="checkbox"/> 150mg/1.14ml Pen <input type="checkbox"/> 150mg/1.14ml Prefilled Syringe <input type="checkbox"/> 200mg/1.14ml Pen <input type="checkbox"/> 200mg/1.14ml Prefilled Syringe	<input type="checkbox"/> Inject 200mg SQ every 2 weeks	2	_____
			<input type="checkbox"/> Alternate Dose: Inject 150mg SQ every 2 weeks	2	_____

Prescription	Medication	Dose/Strength	Directions	Qty	Refills	
	<input type="checkbox"/> Orenzia	<input type="checkbox"/> 250mg Vial <input type="checkbox"/> 125mg/ml Single-Dose PFS <input type="checkbox"/> 125mg/ml Autoinjector	<input type="checkbox"/> Please indicate dose and directions: _____ <input type="checkbox"/> Inject 125mg SQ every week	_____	4	_____
	<input type="checkbox"/> Otezla	<input type="checkbox"/> Starter Pack Tablet (28 days) <input type="checkbox"/> 30mg Tablet	<input type="checkbox"/> Initial Titration Dose: 10mg PO QAM on day 1, then titrate upwards by additional 10mg/day on days 2-5, then 30mg BID thereafter <input type="checkbox"/> Maintenance: 30mg PO BID	_____	1 starter pack 60 tabs	None _____
	<input type="checkbox"/> Rinvoq	<input type="checkbox"/> 15mg ER tablet	<input type="checkbox"/> Take 1 tablet PO QD	_____	30 tabs	_____
	<input type="checkbox"/> Rituxan	<input type="checkbox"/> 500mg/50ml Vial	<input type="checkbox"/> Inject 1000mg IV on days 1 and 15 in combination with methotrexate every 24 weeks <input type="checkbox"/> Methotrexate: _____	_____	4 vials	_____
	<input type="checkbox"/> Simponi	<input type="checkbox"/> 50mg/0.5ml Smartject Autoinjector <input type="checkbox"/> 50mg/0.5ml Prefilled Syringe	<input type="checkbox"/> Inject 50mg SQ once per month	_____	1	_____
		<input type="checkbox"/> Simponi Aria 50mg/4ml	<input type="checkbox"/> Initial Dose: Inject 2mg/kg IV at weeks 0 and 4 <input type="checkbox"/> Maintenance Dose: Inject 2mg/kg IV every 8 weeks thereafter	_____	2 Doses	None _____
	<input type="checkbox"/> Stelara	<input type="checkbox"/> 45mg/0.5ml Prefilled Syringe <input type="checkbox"/> 90mg/ml Prefilled Syringe	<input type="checkbox"/> Initial Dose: Inject <input type="checkbox"/> 45mg or <input type="checkbox"/> 90mg SQ initially and 4 weeks later, followed by every 12 weeks	_____	2	None
			<input type="checkbox"/> Maintenance Dose: Inject <input type="checkbox"/> 45mg or <input type="checkbox"/> 90mg SQ every 12 weeks	_____	1	_____
	<input type="checkbox"/> Tremfya	<input type="checkbox"/> 100mg/ml Single-Dose PFS <input type="checkbox"/> 100mg/ml Autoinjector	<input type="checkbox"/> Initial Dose: Inject 100mg SQ at week 0 and on week 4 <input type="checkbox"/> Maintenance: Inject 100mg SQ every 8 weeks	_____	1 1	1 _____
<input type="checkbox"/> Xeljanz	<input type="checkbox"/> 5mg tablet	<input type="checkbox"/> Take 1 tablet PO BID	_____	60 tabs	_____	
<input type="checkbox"/> Xeljanz XR	<input type="checkbox"/> 11mg tablet	<input type="checkbox"/> Take 1 tablet PO QD	_____	30 tabs	_____	
<input type="checkbox"/> Other	_____	_____	_____	_____	_____	

PRIOR AUTHORIZATION

Prescriber Name: _____ NPI: _____ DEA: _____ LIC#: _____
 Address: _____
 City: _____ Zip: _____ Tel: _____ Fax: _____
 Contact Person: _____

PRESCRIBER SIGNATURE

(Prescriber, please sign and date below)

No stamps. Signature and date must be completed in prescriber's handwriting.
 NY prescriptions must be submitted via e script.

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

Physician's Signature: _____ **Dispense as written (DAW) Date:** ____/____/____

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