PREMIER
PHARMACY SERVICES

Fax: 800.540.3400
Phone: 800.540.4700

To ePrescribe, send prescription to:
Premier Pharmacy Services
410 Cloverleaf Drive
Baldwin Park, CA 91706

RHEUMATOLOGY ORDER FORM

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 Information

Gender: ☐ Male ☐ Female BSA: _____

Height: _____ Weight: _____

TB test given: ☐ Yes ☐ No
Does patient have an active infection?
☐ Yes ☐ No

Start Date: _____

Review Date:_____

Diagnosis: Date of 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: _____

Tried and Failed History:

Medication: _____ Duration: _____

Response: ☐ Intolerant ☐ Ineffective ☐ Contraindicated ☐ Side Effects ☐ Other: _____

Prescription

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

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

Prescriber Information

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:** _____/_____/_____