

Patient Name:		SSN:	DOB:
Address:		City:	State: Zip:
Home Phone:	Cell:	Email:	Gender: Male Female

CLINICAL INFORMATION

Diagnosis: Rheumatoid Arthritis Psoriatic Arthritis Ankylosing Spondylitis Juvenile Rheumatoid Arthritis Iridocyclitis (Uveitis) Other: _____

Allergies: _____ Weight: _____ Height: _____

TB Test Result: _____ Date: _____ HepB Test Result: _____ Date: _____

Prior Failed Meds: Actemra® Cosentyx® Cimzia® Enbrel® Humira® Kevzara® Orencia® Otezla® Other: _____

Prior Methotrexate/Oral Systemic Medications: Yes No Contraindicated

INSURANCE INFORMATION (or attach copy of the cards)

Primary Insurance:	Policy Holder:	Relationship:	Policy #:	Group #:
Secondary Insurance:	Policy Holder:	Relationship:	Policy #:	Group #:

PRESCRIPTION INFORMATION (for IV medication attach a copy of the prescription)

<p>ACTEMRA® (tocilizumab) Maintenance: <input type="checkbox"/> 80 mg/ 4 ml <input type="checkbox"/> 200 mg/ 10 ml <input type="checkbox"/> 400 mg/ 20 ml <input type="checkbox"/> 162 mg/ 0.9 ml prefilled syringe <input type="checkbox"/> 162 mg/ 0.9 ml Pen <input type="checkbox"/> Infuse (<input type="checkbox"/> 4 mg/ kg <input type="checkbox"/> 8 mg/ kg) IV every 4 weeks <input type="checkbox"/> Inject 162 mg SubQ (<input type="checkbox"/> QOW <input type="checkbox"/> QW) Qty: _____ Refills: _____</p> <p>AMJEVITA™ (adalimumab-atto) <input type="checkbox"/> SureClick 40 mg/0.8 mL <input type="checkbox"/> Prefilled Syringe 20 mg/0.4 mL <input type="checkbox"/> Prefilled Syringe 40 mg/0.8 mL <input type="checkbox"/> Inject 40 mg every other week and _____ mg every other week Qty: _____ Refills: _____</p> <p>CIMZIA® (certolizumab pegol) Prefilled Syringe <input type="checkbox"/> Induction: Inject 400 mg (2 x 200 mg/ ml) SubQ at weeks 0, 2, and 4 Qty: 6 Refills: _____</p> <p>Maintenance: <input type="checkbox"/> 400 mg (2 x 200 mg) SubQ every 4 wks <input type="checkbox"/> 400 mg (2 x 200 mg) SubQ every 2 wks <input type="checkbox"/> 200 mg SubQ every 2 wks Qty: _____ Refills: _____</p> <p>COSENTYX™ (secukinumab) 75 mg <input type="checkbox"/> 75 mg PFS <input type="checkbox"/> Induction: Inject 75 mg SubQ at weeks 0, 1, 2, 3 Qty: 28 days Refills: 0 <input type="checkbox"/> Maintenance: Inject 75 mg SubQ on week 4, then every 4 weeks Qty: 28 days Refills: _____</p> <p>150 mg <input type="checkbox"/> 150 mg Sensoready® Pen Kit <input type="checkbox"/> 150 mg PFS <input type="checkbox"/> Induction: Inject 150 mg SubQ at weeks 0, 1, 2, 3 Qty: 5 Refills: _____</p> <p><input type="checkbox"/> Maintenance: Inject 150 mg SubQ on week 4, then every 4 weeks Qty: 28 days Refills: _____</p> <p>300 mg <input type="checkbox"/> UnoReady Pen (1 x 300 mg/2ml) <input type="checkbox"/> Sensoready® Pen Kit (2 x 150 ml) <input type="checkbox"/> PFS (2x 150 ml) <input type="checkbox"/> Induction: Inject 300 mg SubQ at weeks 0, 1, 2, 3 Qty: 28 days Refills: 0 <input type="checkbox"/> Maintenance: Inject 300 mg SubQ on week 4, then every 4 weeks Qty: 28 days Refills: _____</p> <p><input type="checkbox"/> Bridgē®</p> <p>ENBREL® (etanercept) <input type="checkbox"/> Mini Cartridge <input type="checkbox"/> Prefilled Syringe <input type="checkbox"/> Autolinjector <input type="checkbox"/> Vial <input type="checkbox"/> 50 mg <input type="checkbox"/> 25 mg <input type="checkbox"/> Once weekly SubQ <input type="checkbox"/> Twice weekly SubQ Qty: <input type="checkbox"/> 4 <input type="checkbox"/> 8 Refills: _____</p>	<p>HUMIRA® (adalimumab) <input type="checkbox"/> Pen <input type="checkbox"/> Prefilled Syringe <input type="checkbox"/> Citrate Free(CF) <input type="checkbox"/> Original Formula <input type="checkbox"/> 40 mg SubQ every other week <input type="checkbox"/> 40 mg SubQ once a week Qty: 28 days Refills: _____</p> <p>INFLECTRA® (infliximab-dyyb) 100 mg vials <input type="checkbox"/> 3 mg/kg <input type="checkbox"/> 5 mg/ kg <input type="checkbox"/> 10 mg/ kg <input type="checkbox"/> Induction: Give dose as an IV infusion at 0, 2, and 6 weeks Qty: _____ Refills: _____</p> <p><input type="checkbox"/> Maintenance: Give dose as an IV infusion every __ weeks Qty: _____ Refills: _____</p> <p>KEVZARA® (sarilumab) <input type="checkbox"/> Pen <input type="checkbox"/> Prefilled Syringe <input type="checkbox"/> 150 mg <input type="checkbox"/> 200 mg Dosing: Inject SubQ every 2 weeks. Qty: 2 Refills: _____</p> <p>ORENCIA® (abatacept) <input type="checkbox"/> 125 mg Prefilled Syringe <input type="checkbox"/> 250 mg vial <input type="checkbox"/> 125 mg autoinjector <input type="checkbox"/> Inject 125 mg SubQ once a week. <input type="checkbox"/> Infuse __ mg IV at Weeks 0, 2, and 4 then, every 4 weeks <input type="checkbox"/> 4 week supply Refills: _____</p> <p>OLUMIANT® (baricitinib) <input type="checkbox"/> 1 mg tablet <input type="checkbox"/> 2 mg tablet <input type="checkbox"/> Take 1 tablet by mouth daily Qty: _____ Refills: _____</p> <p>OTEZLA® (apremilast) <input type="checkbox"/> Titration Pack: Take by mouth as directed per package instructions Qty: 1 Pack Refills: 0 <input type="checkbox"/> Bridge Pack: Take by mouth as directed per package instructions Qty: 1 Pack Refills: 0 <input type="checkbox"/> Maintenance: 30 mg by mouth twice daily Qty: 30 days Refills: _____</p> <p>REMICADE® (infliximab) 100 mg vials <input type="checkbox"/> Biosimilar authorized <input type="checkbox"/> 3 mg/kg <input type="checkbox"/> 5 mg/kg <input type="checkbox"/> 10 mg/kg <input type="checkbox"/> Induction: Give dose as an IV infusion at 0, 2, and 6 weeks Qty: _____ Refills: 2 <input type="checkbox"/> Maintenance: Give dose as an IV infusion every __ weeks Qty: _____ Refills: _____</p> <p>RINVOQ® (upadacitinib) extended-release tablets <input type="checkbox"/> 15 mg <input type="checkbox"/> 30 mg Once daily PO with or without food Qty: _____ Refills: _____</p>	<p>SIMPONI® (golimumab) 50 mg <input type="checkbox"/> Prefilled Syringe <input type="checkbox"/> Autoinjector Inject SubQ once a month Qty: 1 Refills: _____</p> <p>SKYRIZI™ (risankizumab-rzaa) <input type="checkbox"/> Prefilled Syringe <input type="checkbox"/> Pen <input type="checkbox"/> Inject 150 mg(1 injection) SubQ at Week 0, Week 4, and every 12 weeks thereafter. Qty: 1 Refills: _____</p> <p>STELARA® (ustekinumab) <input type="checkbox"/> 45 mg Prefilled Syringe <input type="checkbox"/> 90 mg Prefilled Syringe Inject contents of 1 syringe SubQ on day 0, then week 4, then every 12 weeks Qty: 1 Refills: _____</p> <p>TALTZ® (ixekizumab) <input type="checkbox"/> Autoinjector <input type="checkbox"/> Prefilled Syringe <input type="checkbox"/> Citrate Free(CF) <input type="checkbox"/> Psoriasis Induction: Inject 160 mg (2 x 80 mg injections) SubQ at week 0; Inject 80 mg at weeks 2, 4, 6, 8, 10, 12 Qty: 8 Refills: _____</p> <p><input type="checkbox"/> Psoriatic Arthritis Induction: Inject 160 mg (2 x 80 mg injections) SubQ at week 0 Qty: 2 Refills: 0 <input type="checkbox"/> Maintenance: 80 mg SubQ every 4 weeks Qty: 1 Refills: _____</p> <p>TREMFYA® (guselkumab) <input type="checkbox"/> Prefilled Syringe <input type="checkbox"/> Autoinjector <input type="checkbox"/> Induction: Inject 100 mg SubQ weeks 0 and 4 Qty: 1 Refills: 1 <input type="checkbox"/> Maintenance: Inject 100 mg SubQ every 8 weeks Qty: 1 Refills: _____</p> <p>XELJANZ® (tofacitinib) <input type="checkbox"/> 5 mg tablet <input type="checkbox"/> 11 mg XR tabs <input type="checkbox"/> Take one 5 mg tablet by mouth twice daily <input type="checkbox"/> Take one 11 mg tablet by mouth once daily Qty: _____ Refills: _____</p> <p><input type="checkbox"/> OTHER</p> <p>STRENGTH:</p> <p>SIG/DIRECTIONS:</p> <p>QUANTITY: REFILLS:</p>
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As required by your state, Prescriber to check "Dispense as written" or handwritten "Brand Medically Necessary" and sign to prevent generic substitution. Dispense as written

PHYSICIAN INFORMATION

Injection Training: Office to Instruct SP to Arrange Teaching

Prescriber Name:	Phone:	Fax:
Office Contact:	Email:	
Address:	Ship To: <input type="checkbox"/> Patient <input type="checkbox"/> MD Office	
NPI #:	Tax ID#:	
Prescription Signature:	Date:	