

**RHEUMATOLOGY**

**PATIENT INFORMATION**

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

**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®  Cimzia®  Cosentyx®  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 #:
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**PRESCRIPTION INFORMATION (for IV medication attach a copy of the prescription)**

<p><b>ACTEMRA® (tocilizumab)</b> 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 PFS <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"/> Every other week <input type="checkbox"/> Every week) Qty: _____ Refills: _____</p>	<p><b>HUMIRA® (adalimumab)</b> <input type="checkbox"/> Pen <input type="checkbox"/> PFS <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><b>SIMLANDI® (adalimumab-ryvk) 40 mg</b> PFS <input type="checkbox"/> Inject SUBQ 40 mg every other week Qty: 1 Refills: _____</p>	
<p><b>AMJEVITA™ (adalimumab-atto)</b> <input type="checkbox"/> SureClick 40 mg/0.8 mL <input type="checkbox"/> PFS 20 mg/0.4 mL <input type="checkbox"/> PFS 40 mg/0.8 mL <input type="checkbox"/> Inject 40 mg every other week and _____ mg every other week Qty: _____ Refills: _____</p>	<p><b>INFLECTRA® (infliximab-dyyb) 100 mg vials</b> <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: _____ <input type="checkbox"/> Maintenance: Give dose as an IV infusion every _____ weeks Qty: _____ Refills: _____</p>	<p><b>SIMPONI® (golimumab) 50 mg</b> <input type="checkbox"/> PFS <input type="checkbox"/> Autoinjector Inject SUBQ once a month Qty: 1 Refills: _____</p>	
<p><b>BIMZELX® (bimekizumab-bkzx) 160 mg</b> <input type="checkbox"/> PFS <input type="checkbox"/> Pen <input type="checkbox"/> Inject 160 mg SUBQ every 4 weeks Qty: 1 Refills: _____</p>	<p><b>KEVZARA® (sarilumab)</b> <input type="checkbox"/> Pen <input type="checkbox"/> PFS <input type="checkbox"/> 150 mg <input type="checkbox"/> 200 mg Dosing: Inject SUBQ every 2 weeks. Qty: 2 Refills: _____</p>	<p><b>SKYRIZI™ (risankizumab-rzaa)</b> <input type="checkbox"/> PFS <input type="checkbox"/> Pen <input type="checkbox"/> Inject 150 mg (1 injection) SUBQ at Week 0, Week 4, and then every 12 weeks Qty: 1 Refills: _____</p>	
<p><b>CIMZIA® (certolizumab pegol) PFS</b> Induction: <input type="checkbox"/> Inject 100 mg SUBQ at weeks 2 and 4 <input type="checkbox"/> Inject 400 mg (2 x 200 mg) SUBQ at weeks 0, 2, and 4 Qty: 6 Refills: _____ Maintenance: <input type="checkbox"/> 50 mg SUBQ every other week <input type="checkbox"/> 100 mg SUBQ every other week <input type="checkbox"/> 200 mg SUBQ every 2 weeks <input type="checkbox"/> 400 mg (2 x 200 mg) SUBQ every 4 weeks <input type="checkbox"/> 400 mg (2 x 200 mg) SUBQ every 2 weeks Qty: _____ Refills: _____</p>	<p><b>OLUMIANT® (baricitinib)</b> <input type="checkbox"/> 1 mg tablet <input type="checkbox"/> 2 mg tablet <input type="checkbox"/> Take 1 tablet PO daily Qty: _____ Refills: _____ <input type="checkbox"/> Bridge*</p>	<p><b>STELARA® (ustekinumab)</b> <input type="checkbox"/> 45 mg PFS <input type="checkbox"/> 90 mg PFS Inject contents of 1 syringe SUBQ on day 0, then week 4, then every 12 weeks Qty: 1 Refills: _____</p>	
<p><b>COSENTYX™ (secukinumab)</b> 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: _____ 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: _____ <input type="checkbox"/> Maintenance: Inject 150 mg SUBQ on week 4, then every 4 weeks Qty: 28 days Refills: _____ 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 (2 x 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><b>ORENCIA® (abatacept)</b> <input type="checkbox"/> 125 mg PFS <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 Qty: 4 week supply Refills: _____</p>	<p><b>TALTZ® (ixekizumab)</b> <input type="checkbox"/> Autoinjector <input type="checkbox"/> PFS <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 Re fills: _____ <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: _____ <input type="checkbox"/> Bridge*</p>	
<p><b>ENBREL® (etanercept)</b> <input type="checkbox"/> Mini cartridge <input type="checkbox"/> PFS <input type="checkbox"/> Autoinjector <input type="checkbox"/> Vial <input type="checkbox"/> 25 mg <input type="checkbox"/> 50 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><b>OTEZLA® (apremilast)</b> <input type="checkbox"/> Titration Pack: Take PO as directed per package instructions Qty: 1 Pack Refills: 0 <input type="checkbox"/> Bridge Pack: Take PO as directed per package instructions Qty: 1 Pack Refills: 0 <input type="checkbox"/> Maintenance: 30 mg PO twice daily Qty: 30 days Refills: _____ <input type="checkbox"/> Bridge*</p>	<p><b>TREMFYA® (guselkumab)</b> <input type="checkbox"/> PFS <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><b>RINVOQ® (upadacitinib) extended-release tablets</b> <input type="checkbox"/> 15 mg <input type="checkbox"/> 30 mg Once daily PO with or without food Qty: _____ Refills: _____</p>	<p><b>REMICADE® (infliximab) 100 mg vials</b> <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><b>XELJANZ® (tofacitinib)</b> <input type="checkbox"/> 5 mg tablet <input type="checkbox"/> 11 mg XR tabs <input type="checkbox"/> Take one 5 mg tablet PO twice daily <input type="checkbox"/> Take one 11 mg tablet PO once daily Qty: _____ Refills: _____</p>	
<p><input type="checkbox"/> OTHER</p> <p><b>STRENGTH:</b> _____</p> <p><b>SIG/DIRECTIONS:</b> _____</p> <p><b>QUANTITY:</b> _____ <b>REFILLS:</b> _____</p>			

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:	City:	State: ZIP:
NPI #:	Tax ID#:	Ship To: <input type="checkbox"/> Patient <input type="checkbox"/> MD Office
Prescriber Signature:	Date:	