

 Please cut along the dotted lines before submitting to a pharmacy.

Date Required: _____		Ship To: ☐ Patient ☐ MD Office ☐ Other: _____		
PATIENT INFORMATION		PRESCRIBER INFORMATION		
Patient Name: _____		Prescriber Name: _____		
Address: _____		Address: _____		
City, State, Zip: _____		City, State, Zip: _____		
Home Phone: _____		Phone: _____		
Cell Phone: _____		Fax: _____		
Date of Birth: _____ Gender: _____		DEA #: _____ NPI #: _____		
Emergency Contact: _____ Phone: _____		Contact Person: _____		
INSURANCE INFORMATION (Please attach the front and back of insurance and prescription drug card.)				
Primary Insurance: _____		ID: _____	Group: _____	
Secondary Insurance: _____		ID: _____	Group: _____	
Prescription Card: _____		BIN: _____	PCN: _____	
To better serve your patient and facilitate insurance authorization, please complete the pertinent sections:				
PATIENT DIAGNOSIS/CLINICAL INFORMATION				
☐ M06.9 Rheumatoid Arthritis ☐ M45.9 Ankylosing Spondylitis ☐ M32.9 Systemic Lupus Erythematosus ☐ M08.00 Unspecified Juvenile Rheumatoid Arthritis ☐ L40.0 Moderate to Severe Plaque Psoriasis ☐ L40.50 Psoriatic Arthritis ☐ L40.59 Psoriasis with Arthropathy ☐ Other: _____		TB/PPD Test: ☐ Positive ☐ Negative ☐ Date Read: _____ HBV: ☐ Positive ☐ Negative ☐ NA ☐ Date Read: _____ Weight: _____ ☐ kg ☐ lbs Height: _____ ☐ cm ☐ in %BSA: _____ Allergies: _____ ☐ NKDA ☐ Pharmacy to coordinate home health nursing visit as necessary: ☐ Yes ☐ No ☐ Home health nursing coordination not necessary: Reason: ☐ MD office to administer to patient ☐ Home health nursing already coordinated		
Prior Medication Failed: _____		Length of Treatment: _____ Reason for Discontinuation: _____		
PRESCRIPTION INFORMATION				
Medication:	Dose/Strength:	Directions:	Quantity:	Refills:
☐ Actemra®	☐ 80mg/4mL ☐ 200mg/10mL ☐ 400mg/20mL	☐ Induction Dose: Infuse 4 mg/kg every 4 weeks ☐ Maintenance Dose: Infuse up to 8 mg/kg every 4 weeks based on clinical response ☐ Other: _____		
☐ Benlysta®	☐ 120mg vial ☐ 400mg vial	☐ Induction Dose: 10mg/kg. Dose = _____ mg at 2 week intervals for the first 3 doses and at 4-week intervals thereafter. Infuse IV over 1 hour ☐ Maintenance Dose: 10mg/kg. Dose = _____ mg every 4 weeks. Infuse IV over 1 hour		
☐ Cosentyx IV®	☐ 125mg/5mL SDV	☐ INITIAL: Infuse 6mg/kg IV over at least 30 minutes at week 0 ☐ MAINTENANCE: Infuse 1.75mg/kg IV over at least 30 minutes at week 4 and every 4 weeks thereafter (maximum maintenance dose 300mg per infusion)		
☐ Krystexxa®		☐ Please refer to Krystexxa® enrollment form.		
☐ Orencia®	☐ 250mg vial	☐ Infuse IV _____ mg at weeks 0, 2 and 4, then every 4 weeks thereafter ☐ Other: _____		
☐ Inflectra®	☐ 100mg vial	☐ INITIAL: Infuse IV _____ mg/kg (Dose _____ mg) at 0, 2, and 6 weeks (Quantity: _____) ☐ MAINTENANCE: Infuse IV _____ mg/kg (Dose _____ mg) every _____ weeks (Quantity: _____) ☐ Other: _____		
☐ Remicade®		☐ Pharmacist will round to the nearest 100 ☐ Give exact dose (do NOT round)		
☐ Renflexis™				
☐ Rituxan®	☐ 100mg/10mL SDV ☐ 500mg/50mL SDV	☐ Infuse IV two doses of 1000 mg separated by 2 weeks ☐ Other: _____		
☐ Saphnelo®	☐ 300mg/2mL SDV	☐ Infuse 300mg IV over at least 30 minutes every 4 weeks		
☐ Simponi Aria®	☐ 50mg/4mL SDV	☐ Infuse 2mg/kg over 30 minutes at weeks 0 and 4, then every 8 weeks thereafter ☐ Other: _____		
☐ Other:				
Premedications & Other Medications: ▶ Infusion supplies as per protocol ▶ Anaphylaxis Kit as per protocol				
☐ Acetaminophen: _____ mg PO prior to infusion ☐ Diphenhydramine: _____ mg ☐ 250mL 0.9% NaCl for hydration ☐ PO ☐ IV ☐ Other: _____				
Flush Protocol: ▶ NaCl 0.9% 10mL ▶ Before and after infusion				

By signing this form and using this pharmacy's services, you are authorizing this pharmacy to serve as your prior authorization designated agent in dealing with prescription and medical insurance companies.

Prescriber Signature: _____ **Date:** _____



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