



Rheumatology

Ph: (214) 919-2090 or (877) 753-6878

Fax: 1 (888) 294-9434

Injection Training:	<input type="checkbox"/> MD Office
	<input type="checkbox"/> Pharmacy to Arrange
Ship To :	<input type="checkbox"/> Patient Home <input type="checkbox"/> MD Office

MAIN POINT OF CONTACT
Name: _____
Phone: _____

PATIENT INFORMATION (Use this area or attach patient demographics)

Name: _____	Phone: _____	Phone 2: _____
Home Address: _____	City: _____	State: _____ Zip Code: _____
DOB: _____ SSN: _____	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Height: _____ Weight: _____ lbs.
Emergency Contact: _____	Phone: _____	

INSURANCE INFORMATION (Use this area or attach copy of insurance card(s))

Primary Insurance: _____	Secondary Insurance: _____
ID#: _____ RxBin: _____	ID#: _____ RxBin: _____
RxGroup: _____ Pcn: _____	RxGroup: _____ Pcn: _____

MEDICAL ASSESSMENT (Use this area or attach patient labs and other authorization information)

Primary Diagnosis: _____	ICD10 Code: _____
--------------------------	-------------------

PRESCRIPTION INFORMATION *(Use this area or attach copy of RX(s))

Medication	Dose/Strength	Directions	Qty	Refills
<input type="checkbox"/> Actemra	162mg/0.9mL prefilled syringe	<input type="checkbox"/> Patients weighing <100kg: inject 162mg SC every other week, followed by an increase to every week based on clinical response. <input type="checkbox"/> Patients weighing ≥100kg: inject 162mg SC every week.		
<input type="checkbox"/> Cimzia	<input type="checkbox"/> Cimzia Starter Kit (6 prefilled Syringes) <input type="checkbox"/> 200mg/1mL prefilled syringe <input type="checkbox"/> 200mg vial	Induction Dose: Inject 400mg SC on day 1, at week 2, and at week 4. <input type="checkbox"/> Maintenance Dose: Inject 200mg SC every OTHER week. <input type="checkbox"/> Maintenance Dose: Inject 400mg SC every FOUR weeks. <input type="checkbox"/> Other: _____	1 kit	0
<input type="checkbox"/> Cosentyx	<input type="checkbox"/> Carton of one 150 mg/mL single-use Sensoready pen (injection) <input type="checkbox"/> Carton of two 150 mg/mL (300 mg dose) single-use Sensoready pens (injection) <input type="checkbox"/> Carton of one 150 mg/mL single-use prefilled syringe (injection) <input type="checkbox"/> Carton of two 150 mg/mL (300 mg dose) single-use prefilled syringe (injection)	Psoriatic Arthritis with Coexistet Moderate to Severe Plaque Psoriasis <input type="checkbox"/> Loading Dose: Inject 300 mg (two injections) SC at weeks 0,1,2,3, and 4. <input type="checkbox"/> Maintenance Dose: Inject 300mg (two injections) SC every 4 weeks. Other Psoriatic Arthritis or Anklosing Spondylitis <input type="checkbox"/> With loading Dose: Inject 150 mg (one injection) SC at weeks 0,1,2,3,and 4, and with every 4 weeks thereafter. <input type="checkbox"/> Without Loading Dose: Inject 150 mg (one injection) SC every 4 weeks. <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Enbrel	<input type="checkbox"/> 25 mg/0.5 mL prefilled syringe <input type="checkbox"/> 25 mg vial <input type="checkbox"/> 50 mg/mL Sureclick Autoinjector <input type="checkbox"/> 50 mg/mL prefilled syringe	<input type="checkbox"/> Inject 25 mg SC TWICE a week (72-96 hours apart) <input type="checkbox"/> Inject 50 mg SC ONCE a week <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Humira	<input type="checkbox"/> 20 mg/0.4mL prefilled syringe <input type="checkbox"/> 40 mg/0.8mL prefilled syringe <input type="checkbox"/> 40 mg/0.8mL pen	<input type="checkbox"/> Inject 20 mg SC every OTHER week <input type="checkbox"/> Inject 40 mg SC every OTHER week. <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Ilaris	180mg lyophilized powder for solution	Patients weighing ≥7.5kg: Inject 4mg/kg (with a maximum of 300mg) SC every 4 weeks. Reconstitution with 1 mL of preservative-free sterile water for injection is required prior to administration of the drug, resulting in a total volume of 1.2mL reconstituted souiton		
<input type="checkbox"/> Orencia	<input type="checkbox"/> 125mg prefilled syringe <input type="checkbox"/> ClickJect Autoinjector 125mg/mL pack of 4	<input type="checkbox"/> Inject 125mg SC every week <input type="checkbox"/> After Single IV Loading Dose: Inject 125mg SC within a day and 125mg SC every week thereafter <input type="checkbox"/> Patients Unable to Receive an IV Loading Dose: Inject 125mg SC every week <input type="checkbox"/> Patients Transitioning from IV Infusion Therapy: Inject 125mg SC instead of the next scheduled IV dose, followed by 125mg SC injections every week thereafter		
<input type="checkbox"/> Simponi	<input type="checkbox"/> 50 mg/0.5mL prefilled SmartJect Autoinjector <input type="checkbox"/> 50 mg/0.5mL prefilled syringe	Inject 50mg SC once a month		
<input type="checkbox"/> Stelara	<input type="checkbox"/> 45mg/0.5mL prefilled syringe <input type="checkbox"/> 90mg/mL prefilled syringe	<input type="checkbox"/> Patients weighing <100kg: inject 45mg SC initially and 4 weeks later, followed by 45mg every 12 weeks. <input type="checkbox"/> Patients weighing ≥100kg: inject 90mg SC initially and 4 weeks later, followed by 90 mg every 12 weeks.		

Prescriber Name: _____	NPI#: _____
Address: _____	City: _____ State: _____ Zip Code: _____
Phone: _____	Fax: _____

*Prescriber Signature: _____	Date: _____
-------------------------------------	--------------------

Confidentiality Statement: This message is intended only for the individual or entity to which it is addressed. It may contain information which may be proprietary and confidential. It may also contain privileged, confidential information which is exempt from disclosure under applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA). If you are not the intended recipient, please note that you are strictly prohibited from disseminating or distributing this information (other than to the intended recipient) or copying this information. If you received this communication in error, please notify the sender immediately at the address and telephone number set forth herein and obtain instructions as to proper destruction of the transmitted material. Thank you.

Please fax completed form to 1 (888) 294-9434