

Patient Information

Date Medication Needed: ____/____/____ Deliver to: Patient's Home Prescriber's Office

Patient's Name: _____ DOB: ____/____/____ Height: _____ Weight: _____
 Gender: _____ SSN: _____ - _____ - _____ Home Phone: _____ Cell Phone: _____
 Address: _____ City: _____ State: _____ ZIP: _____
 Emergency Contact: _____ Relation: _____ Phone: _____
 Allergies: _____

Insurance Information

Primary Insurer: _____ Phone: _____ Person Code: _____
 Policy #: _____ Group #: _____ Rx BIN: _____ Rx PCN: _____
 Secondary Insurer: _____ Phone: _____ Person Code: _____
 Policy #: _____ Group #: _____ Rx BIN: _____ Rx PCN: _____

Prescriber Information

Prescriber's Name: _____ Practice: _____
 Address: _____ City: _____ State: _____ ZIP: _____
 Contact Name: _____ Phone: _____ Fax: _____
 DEA: _____ NPI: _____

Clinical Information

Diagnosis: _____ ICD-10 Code: _____ TB Status: Active PPD(-) Date: ____/____/____
 BMD/T-Score: _____ **History of Fracture:** Site: _____ Date: ____/____/____
 Current Therapy: Yes No Medications: _____
 Prior Failed Medications (Duration, Reason for D/C): _____

Prescription Information

Medication	Dose/Strength	Signature	Qty	Refills
<input type="radio"/> Actemra®	<input type="radio"/> 162mg/0.9ml Prefilled Syringe	<input type="radio"/> Inject 1 syringe SC every week <input type="radio"/> Inject 1 syringe SC every other week	4 Week Supply	
<input type="radio"/> Cimzia® Initial Dose	<input type="radio"/> 200mg Starter Kit (contains 6-200mg PFS)	<input type="radio"/> Inject 400mg SC once, then repeat at weeks 2 and 4	4 Week Supply	NO REFILLS
<input type="radio"/> Cimzia® Maintenance Treatment	<input type="radio"/> 2 x 200mg Prefilled Syringe	<input type="radio"/> 200mg SC once every two weeks <input type="radio"/> 400mg SC once every two weeks	4 Week Supply	
<input type="radio"/> Enbrel® (etanercept)	<input type="radio"/> 50 mg/ml SureClick Autoinjector <input type="radio"/> 50 mg/ml Prefilled Syringe <input type="radio"/> 25mg/0.5ml Prefilled Syringe	<input type="radio"/> Inject 50mg SC once a week <input type="radio"/> Inject 25mg twice a week, 72 to 96 hours apart <input type="radio"/> Other: _____	4 Week Supply	
<input type="radio"/> Forteo®	<input type="radio"/> 600 mcg/2.4ml Prefilled Syringe	<input type="radio"/> Inject 20mcg SC once daily as directed	4 Week Supply	
<input type="radio"/> Humira® <input type="radio"/> Injection Training from My Humira	<input type="radio"/> 40mg/0.8ml Pen <input type="radio"/> 40mg/0.8ml Prefilled Syringe	<input type="radio"/> Inject 40mg SC once a week <input type="radio"/> Inject 40mg SC every other week	<input type="radio"/> 1 Month <input type="radio"/> 3 Month	
<input type="radio"/> Orencia®	<input type="radio"/> 125mg/ml Prefilled Syringe (4 syringes)	<input type="radio"/> Inject 125mg SC once weekly		
<input type="radio"/> Otezla®	<input type="radio"/> 28-Day Titration Starter Pak <input type="radio"/> Bottle of (60) 30mg tabs	<input type="radio"/> (4) 10mg, (4) 20mg, (5) 30mg, plus (42) 30mg tabs <input type="radio"/> 30mg po BID (30 day supply)		
<input type="radio"/> Prolia®	<input type="radio"/> 60mg Prefilled Syringe	<input type="radio"/> Inject 60mg SC once every 6 months		
<input type="radio"/> Simponi®	<input type="radio"/> 50mg/0.5ml Prefilled Syringe <input type="radio"/> 50mg/0.5ml Autoinjector	<input type="radio"/> Inject 50mg once a month	4 Week Supply	
<input type="radio"/> Xeljanz®	<input type="radio"/> 50mg	<input type="radio"/> Take 5mg by mouth twice daily		

Patient Support Programs: Please sign and date below to enroll in the pharmaceutical company assistance program.

Patient's Signature: _____ Date: ____/____/____

I certify that I am prescribing the drug(s) listed above. I authorize Pharmacy to perform the above services on behalf of Physician for the benefit of the patient.

Prescriber's Signature: _____ Date: ____/____/____