

### 1 PATIENT INFORMATION

Patient name \_\_\_\_\_  
 Date of birth \_\_\_\_\_  Male  Female Last 4 digits of SSN \_\_\_\_\_  
 Street address \_\_\_\_\_ Apt # \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Parent/guardian (if applicable) \_\_\_\_\_  
 Home phone \_\_\_\_\_ Work phone \_\_\_\_\_  
 Cell phone \_\_\_\_\_ Evening phone \_\_\_\_\_  
 E-mail address \_\_\_\_\_  
 Insurance company name \_\_\_\_\_  
 Insurance company phone \_\_\_\_\_  
 Insured name \_\_\_\_\_  
 Insured employer \_\_\_\_\_  
 Relationship to patient \_\_\_\_\_  
 Identification # \_\_\_\_\_ Policy/group # \_\_\_\_\_  
 Prescription card  No  Yes If yes, carrier \_\_\_\_\_  
 Policy # \_\_\_\_\_ Group # \_\_\_\_\_  
 Is patient eligible for Medicare?  No  Yes Please attach copy of front and back of patient's insurance cards, if available.

### 2 PRESCRIBER INFORMATION

**All fields must be completed to expedite prescription fulfillment.**

Date \_\_\_\_\_ Time \_\_\_\_\_  
 Prescriber name and title \_\_\_\_\_  
 Office contact \_\_\_\_\_  
 Clinic/hospital affiliation \_\_\_\_\_  
 Street address \_\_\_\_\_ Suite # \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone \_\_\_\_\_ Fax \_\_\_\_\_  
 NPI # \_\_\_\_\_ License # \_\_\_\_\_  
 MD specialty \_\_\_\_\_

To reach your team, call toll-free 1 866 489-1899. Please fax completed form to the RA team 1 866 489-1901.

### 3 CLINICAL INFORMATION

Please complete for specific patient diagnosis.

Primary ICD-9 Code: \_\_\_\_\_  
 Pertinent medical history and clinical course \_\_\_\_\_  
 \_\_\_\_\_  
 Rationale for therapy: ICD-9 Codes  
 714. \_\_\_\_\_ Rheumatoid Arthritis 722. \_\_\_\_\_ Ankylosing Spondylitis  
 696. \_\_\_\_\_ Psoriasis Like Disorders Other \_\_\_\_\_

### 4 PRESCRIBING INFORMATION

**Cimzia**<sup>®</sup> (certolizumab pegol)  
 Dispense:  200 mg prefilled syringe  200 mg lyophilized powder vial  
 Initial dose:  400 mg (given as two 200 mg subcutaneous injections) at weeks 0, 2, and 4 followed by:  
 Maintenance dose:  200 mg subcutaneous injection every other week  
 Other: \_\_\_\_\_

**Enbrel**<sup>®</sup> (etanercept)  
 Dispense:  25 mg prefilled syringe  25 mg multiuse vial  50 mg prefilled syringe  50 mg SureClick<sup>™</sup>  
 Administer: Inject subcutaneously  once per week  twice per week  
 (Juvenile Arthritis) inject 0.8 mg/kg, maximum 50 mg/week.  
 Patient weight (kg): \_\_\_\_\_

**Humira**<sup>®</sup> (adalimumab)  
 Dispense:  40 mg/0.8 mL prefilled syringe  40 mg/0.8 mL pens  20 mg/0.4 mL prefilled syringe  
 Patient weight (kg): \_\_\_\_\_  
 Administer:  Inject 40 mg subcutaneously every other week.  
 (Juvenile Arthritis) Patient weight 15 kg to < 30 kg, inject 20 mg subcutaneously every other week.  
 (Juvenile Arthritis) Patient weight > 30 kg, inject 40 mg every other week.

**Kineret**<sup>®</sup> (anakinra) inject 100 mg subcutaneously every day

**Orencia**<sup>®</sup> (abatacept) Self-Injection  
 Dispense:  125 mg/mL prefilled syringe  
 Administer:  Inject subcutaneously once per week.  
 Loading dose: If intravenous loading dose desired, please also complete intravenous enrollment form.

**Simponi**<sup>™</sup> (golimumab) inject 50 mg subcutaneously once per month  
 Dispense:  50 mg/0.5 ml SmartJect<sup>™</sup>  50 mg/0.5 ml prefilled syringe

If shipped to physician's office, physician accepts on behalf of patient for administration in office  
 Deliver product to:  Office  Patient's home  Clinic/Clinic location

Dispense:  1 month supply  3 months supply Refill \_\_\_\_\_ times  
 By signing below, I certify that the above therapy is medically necessary.  
 Prescriber's printed name \_\_\_\_\_  
 Prescriber's signature (sign below) \_\_\_\_\_ Date \_\_\_\_\_  
 \_\_\_\_\_  
 Dispense as written  Substitution allowed   
(Prescriber attests this is his/her legal signature. NO STAMPS)

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