

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 # _____
 DEA # _____
 Physician Medicaid UPIN # _____
 MD specialty _____

To reach your team, call toll-free 1866 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

- Enbrel®** (etanercept)
 Dose: 25 mg prefilled syringe 25 mg multiuse vial 50 mg prefilled syringe 50 mg SureClick™
 Dispense: once per week twice per week
 (Juvenile Arthritis) inject 0.8 mg/kg, maximum 50 mg/ week. Patient Weight: _____
- Humira®** (adalimumab)
 Dose: 40 mg/0.8 mL PFS 40 mg/0.8 mL Pens 20 mg/0.4 mL PFS
 Dispense: 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®** (anakinra) inject 100 mg subcutaneously every day
- Orencia®** (abatacept) infuse over 30 minutes as directed
 Dose: 500 mg less than 60 kg 750 mg 60 - 100 kg 1000 mg over 100 kg
 (Juvenile Arthritis) 10 mg/kg if less than 75 kg
- Remicade®** (infliximab) infuse NS 250 mL over 2 hours as directed Patient weight: _____
 Dose: 3mg per kg @ 0, 2 and 6 weeks 3mg per kg every 8 weeks
 (Ankylosing Spondylitis) 5mg per kg @ 0, 2 and 6 weeks then every 6 weeks thereafter
 Other Remicade dosing: _____
- Rituxan®** (rituximab) infuse 1000 mg IV bolus on day 1 and 15.
- Simponi™** (golimumab) inject 50mg subcutaneously once per month
 Dose: 50mg/0.5ml SmartJect™ 50mg/0.5ml 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

(Physician attests this is his/her legal signature. **NO STAMPS**)