

**1 PATIENT INFORMATION:**

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Alt. Phone: \_\_\_\_\_  
 Email: \_\_\_\_\_  
 DOB: \_\_\_\_\_ Gender:  M  F Caregiver: \_\_\_\_\_  
 Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Allergies: \_\_\_\_\_

**2 PRESCRIBER INFORMATION:**

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 NPI: \_\_\_\_\_ DEA: \_\_\_\_\_  
 Tax I.D.: \_\_\_\_\_  
 Office Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

**3 STATEMENT OF MEDICAL NECESSITY:** (Please Attach All Medical Documentation)

Date of Diagnosis: \_\_\_\_\_ Patient also taking Methotrexate?  Yes  No  
 ICD-10: \_\_\_\_\_ Serious or active infection present?  Yes  No  
 Other: \_\_\_\_\_ Hep B ruled out or treatment started?  Yes  No  
 TB Test:  Positive  Negative Date: \_\_\_\_\_ Does patient have latex allergy?  Yes  No  
 LFT: ALT: \_\_\_\_\_ AST: \_\_\_\_\_ Date: \_\_\_\_\_

**Prior Failed Treatments:**

Azulfidine®  Celebrex®  Methotrexate  
 Biologics  Corticosteroids  Others  
 Calcipotriene  Indocin®

**Indicate Drug Name and Length of Treatment:**

\_\_\_\_\_  
 \_\_\_\_\_

**If Prior Authorization is denied, recommended formulary alternatives will be provided to the prescriber based upon the patient's insurance coverage.**

**4 INJECTION TRAINING:**  Pharmacist to Provide Training  Patient Trained in MD Office  Manufacturer Nurse Support

**5 PRODUCT DELIVERY:**  Patient's Home  Physician's Office  Pharmacy to Coordinate

**6 INSURANCE INFORMATION:** Please Include Front and Back Copies of Pharmacy and Medical Card

**PRESCRIPTION INFORMATION:** (Please be sure to choose both induction and maintenance dose where applicable)

Patient Name: \_\_\_\_\_ Patient's Date of Birth: \_\_\_\_\_

Medication	Dosage & Strength	Direction	QTY	Refills
<input type="checkbox"/> ACTEMRA®	<input type="checkbox"/> 162mg/0.9ml Prefilled Syringe	<input type="checkbox"/> Inject 162mg SC every other week (< 220 lbs) <input type="checkbox"/> Inject 162mg SC every week (> 220 lbs) <input type="checkbox"/> Inject 162mg SC every 2 weeks (> 66lbs) <input type="checkbox"/> Inject 162mg SC every 3 weeks (< 66lbs)		
<input type="checkbox"/> CIMZIA®	<input type="checkbox"/> Prefilled Syringe Starter Kit <input type="checkbox"/> 200mg/ml Prefilled Syringe <input type="checkbox"/> 200mg Lyophilized Powder Vial	<input type="checkbox"/> <b>Induction Dose:</b> Inject 400mg SC on day 1, day 14 and day 28 <input type="checkbox"/> <b>Maintenance:</b> Inject 400mg SC every 4 weeks <input type="checkbox"/> <b>Maintenance:</b> Inject 200mg SC every other week	6 2	0
<input type="checkbox"/> ENBREL®	<input type="checkbox"/> 50mg/ml Sureclick Autoinjector <input type="checkbox"/> 50mg/ml Enbrel Mini™ Prefilled Cartridge <input type="checkbox"/> For Enbrel Mini™ only: AutoTouch™ Autoinjector <input type="checkbox"/> 50mg/ml Prefilled Syringe <input type="checkbox"/> 25mg/ml Prefilled Syringe <input type="checkbox"/> 25mg/ml Vial	<input type="checkbox"/> Inject 50mg SC once a week <input type="checkbox"/> Inject 25mg SC twice a week (3-4 days apart) <input type="checkbox"/> Other _____	4 1	
<input type="checkbox"/> HUMIRA®	<input type="checkbox"/> 40mg/0.8ml Pen <input type="checkbox"/> 40mg/0.8ml Prefilled Syringe	<input type="checkbox"/> Inject 40mg SC every other week <input type="checkbox"/> Patient has signed <input type="checkbox"/> Inject 40mg SC once a week <i>HUMIRA Complete form</i>		
<input type="checkbox"/> KEVZARA®	<input type="checkbox"/> 150mg/1.14ml Prefilled Syringe <input type="checkbox"/> 200mg/1.14ml Prefilled Syringe	<input type="checkbox"/> Inject 150mg SC every 2 weeks <input type="checkbox"/> Inject 200mg SC every 2 weeks	2 2	
<input type="checkbox"/> ORENCIA®	<input type="checkbox"/> 250mg Lyophilized Powder Vial <input type="checkbox"/> 125mg/ml ClickJect™ Autoinjector <input type="checkbox"/> 50mg/0.4ml Prefilled Syringe <input type="checkbox"/> 87.5mg/0.7ml Prefilled Syringe <input type="checkbox"/> 125mg/ml Prefilled Syringe	<input type="checkbox"/> <b>Induction Dose:</b> Patient Weight < 132 lbs: 500mg; 132-220 lbs: 750mg; > 220 lbs: 1000mg administered IV, then inject 125mg SC within 24 hours <input type="checkbox"/> Inject 50mg SC once a week (10 to less than 25kg) <input type="checkbox"/> Inject 87.5mg SC once a week (25 to less than 50kg) <input type="checkbox"/> Inject 125mg SC once a week (50kg or more)	4 4 4	0
<input type="checkbox"/> OTEZLA® (for PsA)	<input type="checkbox"/> Starter Pack (Titration) <input type="checkbox"/> 30mg Tablets	<input type="checkbox"/> <b>Starter Pack:</b> Take one tablet in the morning on day 1, then take one tablet in the morning and one tablet in the evening as directed on the starter pack <input type="checkbox"/> <b>Maintenance:</b> Take one 30mg tablet by mouth twice daily	1 60	0
<input type="checkbox"/> SIMPONI®	<input type="checkbox"/> 50mg/0.5ml Smartject Autoinjector <input type="checkbox"/> 50mg/0.5ml Prefilled Syringe	<input type="checkbox"/> Inject 50mg SC once a month	1	
<input type="checkbox"/> STELARA® (for PsA)	<input type="checkbox"/> 45mg/0.5ml Prefilled Syringe (for < 220 lbs) <input type="checkbox"/> 90mg/1ml Prefilled Syringe (for > 220 lbs) <input type="checkbox"/> Yes or <input type="checkbox"/> No: <i>STELARA SELF-INJECTION: Healthcare provider certifies that patient has been trained and is eligible for self-injection</i>	<input type="checkbox"/> <b>Induction Dose:</b> Inject 1 prefilled syringe SC on day 1 <input type="checkbox"/> <b>Maintenance:</b> Inject 1 prefilled syringe SC on day 29, and every 12 weeks thereafter	1 1	0
<input type="checkbox"/> XELJANZ®	<input type="checkbox"/> 5mg Tablet	<input type="checkbox"/> Take one 5mg tablet by mouth twice a day	60	
<input type="checkbox"/> XELJANZ® XR	<input type="checkbox"/> 11mg Tablet	<input type="checkbox"/> Take one 11mg tablet once a day	30	
<input type="checkbox"/> RASUVO®	<input type="checkbox"/> _____	<input type="checkbox"/> _____		
<input type="checkbox"/> COLCIGEL®	<input type="checkbox"/> _____	<input type="checkbox"/> _____		
<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____		

**PRESCRIBER SIGNATURE:** I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Substitution Permitted**

**Dispense As Written**

Prior authorization approval and insurance benefits will be determined by the payor based upon the patient's eligibility, medical necessity, and the terms of the patient's coverage, among other things. Participation in this program is not a guarantee of prior authorization or of payment.

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