

Patient Information

Deliver to: Patient's Home Provider's Office

Date: _____

Name: _____ Date of Birth: _____

Prescriber Name, Address, & Phone number: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ - _____ - _____ E-Mail: _____

Clinical Information**Diagnosis/ICD-10:**

- Rheumatoid Arthritis (M06.9)
 Ankylosing Spondylitis (M45.9)
 Psoriatic Arthritis (L40.5)
 Other: _____

Date of Diagnosis: _____

• Is Patient Taking Methotrexate?

 Yes No

• TB/PPD Test Given?

 Yes No

• Date of Negative Test:

• Other Relevant Clinical Info:

Past & Current Tried Therapies:

Medication	Dose/Strength	Directions	Quantity	Refills
<input type="checkbox"/> Actemra	162mg/0.9ml Syringes	<100Kg <input type="checkbox"/> Inject 162mg SQ every other week <input type="checkbox"/> Inject 162mg SQ every week ≥100Kg <input type="checkbox"/> Inject 162mg SQ every week	<input type="checkbox"/> 2 PFS <input type="checkbox"/> 4 PFS	
<input type="checkbox"/> Cimzia	<input type="checkbox"/> 200mg Syringes Starter Kit (6 syringes) <input type="checkbox"/> 200mg Prefilled Syringe <input type="checkbox"/> 200mg Vial	<input type="checkbox"/> Initial Dose: Inj. 400mg SQ at weeks 0, 2, & 4 <input type="checkbox"/> Inj. 200mg SQ every OTHER week <input type="checkbox"/> Inj. 400mg SQ every 4 weeks	1 Kit (6 syr) 1 Kit (2 syr)	
<input type="checkbox"/> Cosentyx	<input type="checkbox"/> 150mg Sensoready Pen <input type="checkbox"/> 150mg 2pk Sensoready Pen <input type="checkbox"/> 150mg/mL Prefilled Syringe <input type="checkbox"/> 150mg/mL 2 pack Prefilled Syringe	<input type="checkbox"/> Initial Dose: Inj. 150mg SQ @ weeks 0, 1, 2, 3, & 4 <input type="checkbox"/> Maintenance Dose: Inj. 150mg SQ every 4 weeks <input type="checkbox"/> Initial Dose: Inj. 300mg (2 injections) SQ @ weeks 0, 1, 2, 3, 4 <input type="checkbox"/> Maintenance Dose: Inj. 300mg (2 injections) SQ every 4 weeks		
<input type="checkbox"/> Enbrel	<input type="checkbox"/> 50mg/mL Sureclick™ Autoinjector <input type="checkbox"/> 50mg/mL Prefilled Syringe <input type="checkbox"/> 25mg/0.5mL Prefilled Syringe <input type="checkbox"/> 25mg Vial	<input type="checkbox"/> Inj. 25mg SQ TWICE a week(72-96 hours apart) <input type="checkbox"/> Inj. 50mg SQ TWICE a week(72-96 hours apart) <input type="checkbox"/> Inj. 50mg SQ ONCE a week		
<input type="checkbox"/> Humira	<input type="checkbox"/> 20mg Prefilled Syringe <input type="checkbox"/> 40mg Pens <input type="checkbox"/> 40mg Prefilled Syringe	<input type="checkbox"/> Inject 20mg SQ every OTHER week <input type="checkbox"/> Inject 40mg SQ every OTHER week <input type="checkbox"/> Inject 40mg SQ EVERY week		
<input type="checkbox"/> Orencia	<input type="checkbox"/> 125mg Prefilled Syringe <input type="checkbox"/> 125mg Clickject	Inj. 125mg SQ Once per week		
<input type="checkbox"/> Otezla	<input type="checkbox"/> Titration Starter Pack <input type="checkbox"/> 30mg Tablets	Day 1: 10mg PO in the morning Day 2: 10mg PO in the morning and 10mg in the evening Day 3: 10mg PO in the morning and 20mg in the evening Day 4: 20mg PO in the morning and 20mg in the evening Day 5: 20mg PO in the morning and 30 mg in the evening Day 6 and thereafter: 30mg PO BID <input type="checkbox"/> Maintenance Dose: 30mg po BID <input type="checkbox"/> Other:	1 Pack	0
<input type="checkbox"/> Otrexup	_____mg/0.4mL Syringes (4 Pack of Syringes)	Inject _____mg SQ Once Weekly		
<input type="checkbox"/> Rasuvo	_____mg Autoinjector (4 Pack of Syringes)	Inject _____mg SQ Once Weekly		
<input type="checkbox"/> Simponi	<input type="checkbox"/> 50mg/mL Smartject™ Autoinjector <input type="checkbox"/> 50mg/0.5mL Prefilled Syringe	<input type="checkbox"/> Inj. 50mg ONCE a month		
<input type="checkbox"/> Stelara	<input type="checkbox"/> 45mg/0.5mL Syringe <input type="checkbox"/> 90mg/mL Syringe	<input type="checkbox"/> Inject _____mg SQ initially and 4 weeks later, then inject 45mg every 12 weeks for maintenance <input type="checkbox"/> Other:		
<input type="checkbox"/> Xeljanz	<input type="checkbox"/> 5mg Tablets <input type="checkbox"/> 11mg XR Tablets	<input type="checkbox"/> Take one 5mg tablet PO twice daily <input type="checkbox"/> Take one 11mg XR Tablet Daily		
Other				

Prescriber Signature

Dispense As Written

Substitution Permissible