

Patient Information

Patient Name: _____
 Date of Birth: _____ Sex: _____ SS# _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Home Phone: _____ Work Phone: _____
 Cell Phone: _____ E-mail: _____
 Please attach copy of front and back of patient's prescription ins. card(s) if applicable
 Insurance Company Name: _____
 Insurance Company Phone: _____
 Policy holder: _____
 Policy holder Employer: _____
 Relationship to Patient: _____
 ID# _____ Group# _____
 RxBIN: _____ RxPCN: _____

Prescriber Information

Practice/ Organization Name: _____
 Physician Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone#: _____ Fax#: _____
 DEA# _____ NPI# _____
 License#: _____ Medicaid UPIN#: _____
 Physician Specialty: _____
Date Shipment Needed: _____
Ship to: ☐ **Patient** ☐ **Prescriber** ☐ **Infusion Clinic**
 Shipment Address: _____ Attn: _____
 City: _____ State: _____ Zip: _____
If shipped to the physician's office, physician accepts on behalf of patient for administration in office.

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Clinical Information and Prescription

Diagnosis: _____
 ___ 714.0 Rheumatoid Arthritis ___ 720.0 Ankylosing Spondylitis ___ 696.0 Psoriatic Arthritis
 ___ 714.3 Juvenile chronic polyarthritis ___ Other: _____
 Date of Diagnosis or Years with Disease: _____
 Patients Allergies: _____
 DAS Score: _____ MHAQ Score: _____ Latex allergy: ___yes ___no
 Patient Weight: _____ Patient Height: _____
 Has the patient had a NEGATIVE tuberculin skin test?: ___yes ___no
 Is the patient a carrier of the Hepatitis B virus? ___yes ___no
 Prior DMARD's and length of treatment: _____
 Expected First Dose Date: _____ Injection Instruction needed: ___Yes ___No

☐ **Enbrel® (etanercept)**

Dose: ___ 25mg prefilled syringe ___ 25mg multiuse vial ___ 50mg prefilled syringe ___ 50mg SureClick
 Dispense: ___ once per week ___ twice per week ___ (JIA) inject 0.8mg/kg, max 50mg/week

☐ **Humira® (adalimumab)**

Dose: ___ 40mg/0.8ml PFS ___ 40mg/0.8ml pens ___ 20mg/0.4ml PFS
 Dispense: ___ 40mg SC every other week (also JIA, pat. weight >30kg) ___ 40mg SC every week
 ___ 20mg SC every other week (pat. weight 15kg to <30kg, JIA) ___ Other: _____

☐ **Kineret® (anakinra)**

___ Inject 100mg SC every day

☐ **Orencia® (abatacept)** infuse over 30 minutes as directed

Dose: ___ 500mg (pat. <60kg) ___ 750mg (60-100kg) ___ 1000mg (>100kg)
 ___ 10mg/kg if less than 75kg (JA) OR ___ 125mg PFS SC (1X Weekly)

☐ **Remicade® (infliximab)** infuse NS 250ml over 2 hours as directed

Dose: ___ 3mg/kg @ 0, 2, 6 weeks ___ 3mg/kg every 8 weeks
 ___ 5mg/kg @ 0, 2, 6 weeks then every 6 weeks thereafter (Ankylosing Spon.)
 ___ Other Remicade dosing: _____

☐ **Rituxan® (rituximab)**

___ infuse 1000mg 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

☐ **Cimzia® (certolizumab)**

Initial Dose: ___ 400mg SC @ 0, 2, 4 weeks prefilled syringe
 ___ 400mg SC @ 0, 2, 4 weeks lyophilized powder (administered in office)
 Maintenance Dose: ___ 400mg SC every 4 weeks ___ 400mg SC every 2 weeks

☐ **Actemra® (Tocilizumab)** ___ mg/kg IV

Given over 1 hour every ___ weeks

☐ **Xeljanz® (Tofacitinb)** ___ 5 mg PO twice daily

Quantity Prescribed: ☐ QS 30 days ☐ QS 90 days ☐ Other: _____

Refills Authorized: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 6 mos ☐ 1 yr ☐ Other: _____

X _____

Physician Signature (no stamps)

Date