

Needs by Date: _____ Ship to Patient's Home Prescriber 1st Order Only Prescriber All Orders

PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name: _____ Address: _____ City, State, Zip: _____ Home Phone: _____ Cell Phone: _____ Date of Birth: _____ Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Prescriber Name: _____ Address: _____ City, State, Zip: _____ Phone: _____ Fax: _____ DEA#: _____ NPI#: _____ Contact Person: _____

INSURANCE INFORMATION (Please attach the front and back of insurance and prescription drug card)

Primary Insurance: _____	ID#: _____	Group: _____
Secondary Insurance: _____	ID#: _____	Group: _____
Prescription Card: _____	ID#: _____	BIN: _____ PCN: _____ Group: _____

DIAGNOSIS & CLINICAL ASSESSMENT (Fill in below or attach lab work)

Primary Diagnosis Code & Condition: _____ Joints Affected: _____

Number of Tender Joints: _____ Number of Swollen Joints: _____ Current Weight: _____ Date: _____

New Therapy Induction | Stop Date: _____ Therapy Change | Stop Date: _____

Therapy Continuation | Stop Date: _____ Weeks Completed: 0 2 4 6 Allergies: _____

ESR & Date: _____ CRP & Date: _____ TB Results & Date: _____

Actemra® (tocilizumab)	Enbrel® (etanercept)	Humira® (adalimumab)
<input type="checkbox"/> 80 mg/4 mL Vial <input type="checkbox"/> 162 mg Syringe <input type="checkbox"/> 200 mg/10 mL Vial <input type="checkbox"/> 400 mg/20 mL Vial SIG: _____ QTY: _____ Refill: _____	<input type="checkbox"/> 25 mg Syringe <input type="checkbox"/> 25 mg Vial <input type="checkbox"/> 50 mg Syringe <input type="checkbox"/> 50 mg SureClick Pen SIG: _____ QTY: _____ Refill: _____	<input type="checkbox"/> 10 mg Syringe <input type="checkbox"/> 20 mg Syringe <input type="checkbox"/> 40 mg Syringe <input type="checkbox"/> 40 mg Pen SIG: _____ QTY: _____ Refill: _____

Cimzia® (certolizumab pegol)	Kineret® (anakinra)	Prolia® (denosumab)
<input type="checkbox"/> 2 x 200 mg Kit <input type="checkbox"/> Syringe <input type="checkbox"/> Vial SIG: _____ QTY: _____ Refill: _____	<input type="checkbox"/> 100 mg Syringe SIG: _____ QTY: _____ Refill: _____	<input type="checkbox"/> 60 mg PFS <input type="checkbox"/> 60 mg Vial SIG: _____ QTY: _____ Refill: _____

Remicade® (infliximab)	Rituxan® (rituximab)	Orencia® (abatacept)
<input type="checkbox"/> 100 mg Vial SIG: _____ QTY: _____ Refill: _____	<input type="checkbox"/> 100 mg Vial <input type="checkbox"/> 500 mg Vial SIG: _____ QTY: _____ Refill: _____	Bone Density Score: _____ Date of Test: _____

Xeljanz® (tofacitinib)	Stelara® (ustekinumab)	Simponi® (golimumab)
<input type="checkbox"/> 5 mg Tablet SIG: _____ QTY: _____ Refill: _____	PFS: <input type="checkbox"/> 1 x 45mg/0.5mL <input type="checkbox"/> 1 x 90mg/mL <input type="checkbox"/> Inject 45mg SQ on Day 1 (<100kg) <input type="checkbox"/> Inject 90mg SQ on Day 1 (>100kg) <input type="checkbox"/> Inject 45mg SQ on Day 29 and every 12 weeks thereafter (<100kg) <input type="checkbox"/> Inject 90mg SQ on Day 29 and every 12 weeks thereafter (>100kg) QTY: _____ Refill: _____	<input type="checkbox"/> (4) 125 mg Prefilled Syringe <input type="checkbox"/> 250mg Vial SIG: _____ QTY: _____ Refill: _____

Other/Notes: _____ _____ _____	<input type="checkbox"/> 50 mg Syringe <input type="checkbox"/> 50 mg Smartject <input type="checkbox"/> 50 mg Vial (Aria) SIG: _____ QTY: _____ Refill: _____	
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Prescriber Signature: _____ **DAW (Dispense as Written)** Y N **Date:** _____

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