Rheumatology (A-O)

Rx International Pharmacy

Phone: (305) 221-1421
Fax: (305) 221-3275

(Actemra®, Cimzia®, Cosentyx®, Enbrel®, Humira®, Orencia®)

Patient information

Patient Name: _____ DOB: _____
Sex: ❑ Female ❑ Male SS #: _____
1˚ Language: _____ Wt: _____ ❑kg ❑lbs Ht: _____❑cm ❑in
Address: _____
Apt/Suite: _____ City: _____ State: _____ Zip: _____
Phone: _____ Alternate Phone: _____
Caregiver Name: _____ Relation: _____
Local Pharmacy: _____ Phone: _____
Insurance Plan: _____ Plan ID #: _____
Please fax a copy of front and back of the insurance card(s).

Prescriber + Shipping Information

Prescriber Name: _____
NPI #: _____
Address: _____
Apt/Suite #_____ City:_____ State: _____ Zip: _____
Contact: _____
Phone: _____ Alternate: _____
Fax: _____
Email Address: _____
Preferred method to contact office: ❑ Phone ❑ Fax ❑ Email
If shipping to prescriber: ❑ 1st Fill ❑ Always ❑ Never

Clinical Information (Please fax all pertinent clinical and lab information)

ICD-10/Diagnosis Code: ❑ M06.9 (Rheumatoid Arthritis) ❑ M08.0 (Juvenille Idiopathic Arthritis) ❑ L40.59 (Psoriatic Arthritis)
❑ L40.54 (Psoriatic Juvenille Arthritis) ❑ M45.9 (Ankylosing Spondylitis) ❑ Other: _____
Date of Diagnosis: _____ Date of negative TB test: _____ Any prior treatment: ❑ No ❑ Yes (provide information below)

Prior Therapy	Reason for Discontinuation of Therapy	Approximate Start Date	Approximate End Date

Comorbidities: _____
Concomitant Medications: _____
Allergies: ❑ NKDA ❑ Other: _____

Prescription

❑ **Actemra®**	❑ Inject 162 mg subcut every other week (<100 kg) ❑ Inject 162 mg subcut every week (≥100 kg) Qty: ❑ 2 PFS ❑ 4 PFS Refills: _____
❑ **Cimzia®**	Starter: ❑ Inject 400 mg subcut at weeks 0, 2 and 4 Qty: ❑ 1 starter kit (6 x 200mg/mL PFS) ❑ 3 cartons (2 x 200mg/mL vials/carton)
	Maintenance: ❑ Inject 400 mg subcut every 4 weeks ❑ Inject 200 mg subcut every 2 weeks Qty: 1 carton (2 x 200 mg) ❑ PFS ❑ Vials Refills: _____
❑ **Cosentyx®**	To order Cosentyx® please see the Novartis service request form at cosentyxhcp.com/get-your-patients-started To ensure prescription is forwarded to Diplomat, specify Diplomat as the preferred specialty pharmacy.
❑ **Enbrel®**	❑ Inject 50 mg subcut every week ❑ _____ Qty: ❑ 1 carton (4 x 50mg/mL) ❑ _____ ❑ SureClick® ❑ PFS ❑ Vials Refills: _____
❑ **Humira®**	❑ Inject 40 mg subcut every other week (≥30 kg) ❑ Inject 40 mg subcut **once a week** (≥30 kg) ❑ Inject 20 mg subcut every other week (15 to <30 kg) ❑ Inject 10 mg subcut every other week (10 to <15 kg) Qty: ❑ **1** carton (2 x 40 mg/0.8mL **Pens**) ❑ **1** carton (2 x 40 mg/0.8mL **PFS**) ❑ **2** carton (2 x 40 mg/0.8mL **Pens**) ❑ **2** carton (2 x 40 mg/0.8mL **PFS**) ❑ 1 carton (2 x **20** mg/0.8mL PFS) ❑ 1 carton (2 x **10** mg/0.8mL) Refills: _____
❑ **Orencia®** **(JIA <75 kg) ONLY**	Starter: ❑ Infuse 10 mg/kg at weeks 0, 2 and 4 Qty: _____ vials (250 mg/vial)
	Maintenance: ❑ Infuse 10 mg/kg every 4 weeks Qty: _____ vials (250 mg/vial) Refills: _____
❑ **Orencia®**	Starter: ❑ Infuse weight-range based at week 0 **Only** ❑ Infuse weight-range based at weeks 0, 2 and 4 Qty: 250 mg/vial ❑ 2 vials (< 60 kg) ❑ 3 vials (60 - 100 kg) ❑ 4 vials (> 100 kg)
	Maintenance: ❑ Inject 1 PFS (125 mg) subcut once weekly ❑ Infuse weight-range based every 4 weeks Qty: ❑ 4 PFS ❑ 2 vials (< 60 kg) ❑ 3 vials (60 - 100 kg) ❑ 4 vials (> 100 kg) Refills: _____

Otezla® ,Simponi®, Simponi® Aria, Stelara®, Xeljanz® are available on the Rheumatology Enrollment Form O-Z

Injection Training Provided by: ❑ Prescriber's Office ❑ Pharmacy ❑ Other: _____

Prescription will be filled with generic (if available) unless prescriber writes "DAW" (dispense as written): _____

Prescriber's Signature:_____ Date: _____

I authorize Rx International Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.