Rheumatology (O-Z)

(Otezla®, Simponi®, Simponi® Aria, Stelara®, Xeljanz®)

Rx International Pharmacy

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

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) ❑ _____
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®, Cimzia®, Cosentyx®, Enbrel®, Humira®, Orencia® are available on the Rheumatology Enrollment Form A-O

❑ Otezla®

Starter: ❑ Take as directed per package instructions
Qty: 55 tablets (one 28-day pack)

Maintenance: ❑ Take 30 mg by mouth twice daily ❑ _____
Qty: ❑ 60 tablets ❑ _____ Refills: _____

❑ Simponi®

❑ Inject 50 mg subcut once monthly
Qty: 1 box (1 x 50 mg/0.5 mL) ❑ SmartJet™ ❑ PFS Refills: _____

❑ Simponi® Aria™

Starter: ❑ Infuse 2 mg/kg over 30 minutes at weeks 0
Qty: _____ vials (50 mg/ 4 ml vial) Refills: 0

Maintenance: ❑ Infuse 2 mg/kg over 30 minutes at week 4 and every 8 weeks thereafter
Qty: _____ vials (50 mg/ 4 ml vial) Refills: _____

❑ Stelara®

Starter: ❑ Inject 45 mg/0.5 mL subcut on day 1 (≤100 kg or 220 lbs)
❑ Inject 90 mg/0.5 mL subcut on day 1 (>100 kg or 220 lbs)
Qty: 1 PFS Refills: 0

Maintenance: ❑ Inject 45 mg/0.5 mL subcut on day 29 and every 12 weeks thereafter (≤100 kg or 220 lbs)
❑ Inject 90 mg/0.5 mL subcut on day 29 and every 12 weeks thereafter (>100 kg or 220 lbs)
Qty: 1 PFS Refills: _____

Patient eligible for self-administeration: ❑ Yes ❑ No

❑ Xeljanz®

❑ Take 5 mg by mouth twice daily ❑ _____
Qty: ❑ 60 tablets ❑ _____ Refills: _____

❑ _____

Directions: _____
Strength: _____ Qty: _____ Refills: _____

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.