



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

Patient information	Prescriber + Shipping Information
Patient Name: _____ DOB: _____ Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male SS #: _____ 1 st Language: _____ Wt: _____ <input type="checkbox"/> kg <input type="checkbox"/> lbs Ht: _____ <input type="checkbox"/> cm <input type="checkbox"/> 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 Name: _____ NPI #: _____ Address: _____ Apt/Suite # _____ City: _____ State: _____ Zip: _____ Contact: _____ Phone: _____ Alternate: _____ Fax: _____ Email Address: _____ Preferred method to contact office: <input type="checkbox"/> Phone <input type="checkbox"/> Fax <input type="checkbox"/> Email If shipping to prescriber: <input type="checkbox"/> 1st Fill <input type="checkbox"/> Always <input type="checkbox"/> Never

Clinical Information (Please fax all pertinent clinical and lab information)			
ICD-10/Diagnosis Code: <input type="checkbox"/> M06.9 (Rheumatoid Arthritis) <input type="checkbox"/> M08.0 (Juvenile Idiopathic Arthritis) <input type="checkbox"/> L40.59 (Psoriatic Arthritis) <input type="checkbox"/> L40.54 (Psoriatic Juvenile Arthritis) <input type="checkbox"/> M45.9 (Ankylosing Spondylitis) <input type="checkbox"/> _____			
Date of Diagnosis: _____ Date of negative TB test: _____ Any prior treatment: <input type="checkbox"/> No <input type="checkbox"/> Yes (provide information below)			
Prior Therapy	Reason for Discontinuation of Therapy	Approximate Start Date	Approximate End Date
_____	_____	_____	_____
_____	_____	_____	_____
Comorbidities: _____ Concomitant Medications: _____ Allergies: <input type="checkbox"/> NKDA <input type="checkbox"/> Other: _____			

Prescription

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

<input type="checkbox"/> Otezla®	Starter: <input type="checkbox"/> Take as directed per package instructions Qty: 55 tablets (one 28-day pack) Maintenance: <input type="checkbox"/> Take 30 mg by mouth twice daily <input type="checkbox"/> _____ Qty: <input type="checkbox"/> 60 tablets <input type="checkbox"/> _____ Refills: _____
<input type="checkbox"/> Simponi®	<input type="checkbox"/> Inject 50 mg subcut once monthly Qty: 1 box (1 x 50 mg/0.5 mL) <input type="checkbox"/> SmartJet™ <input type="checkbox"/> PFS Refills: _____
<input type="checkbox"/> Simponi® Aria™	Starter: <input type="checkbox"/> Infuse 2 mg/kg over 30 minutes at weeks 0 Qty: _____ vials (50 mg/ 4 ml vial) Refills: 0 Maintenance: <input type="checkbox"/> Infuse 2 mg/kg over 30 minutes at week 4 and every 8 weeks thereafter Qty: _____ vials (50 mg/ 4 ml vial) Refills: _____
<input type="checkbox"/> Stelara®	Starter: <input type="checkbox"/> Inject 45 mg/0.5 mL subcut on day 1 (≤100 kg or 220 lbs) <input type="checkbox"/> Inject 90 mg/0.5 mL subcut on day 1 (>100 kg or 220 lbs) Qty: 1 PFS Refills: 0 Maintenance: <input type="checkbox"/> Inject 45 mg/0.5 mL subcut on day 29 and every 12 weeks thereafter (≤100 kg or 220 lbs) <input type="checkbox"/> 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-administration: <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Xeljanz®	<input type="checkbox"/> Take 5 mg by mouth twice daily <input type="checkbox"/> _____ Qty: <input type="checkbox"/> 60 tablets <input type="checkbox"/> _____ Refills: _____
<input type="checkbox"/> _____	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.

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