

DATE: _____ NEEDS BY DATE: _____ SHIP TO: PATIENT OFFICE - FIRST DOSE OFFICE - ALL DOSES OTHER _____

PATIENT INFORMATION		
Patient Name		
Address		
City	State	Zip
Main Phone	Alternative Phone	<input type="checkbox"/> Male <input type="checkbox"/> Female
Social Security #		Date of Birth

PRESCRIBER INFORMATION		
Prescriber Name		
Prescriber Type	<input type="checkbox"/> Physician (MD or DO)	<input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> Physician's Assistant
Supervising Physician (If prescriber is a NP or PA)		
DEA #	NPI #	Tax ID #
Address		
City	State	Zip
Phone	Fax	
Contact Person		

CLINICAL INFORMATION			
Diagnosis: <input type="checkbox"/> M06.9 Rheumatoid Arthritis <input type="checkbox"/> H20.0 Iridocyclitis (Uveitis)	<input type="checkbox"/> L40.50 Psoriatic Arthritis <input type="checkbox"/> Other: _____	<input type="checkbox"/> M45.9 Ankylosing Spondylitis DX Code: _____	<input type="checkbox"/> M08.00 Juvenile Rheumatoid Arthritis
Patient Allergies: _____	Hepatitis Test Result: _____	Patient Weight: _____	Patient Height: _____
TB/PPD Test given? <input type="checkbox"/> Yes <input type="checkbox"/> No Test Date: _____	Test Results: _____		
Prior Failed Meds: <input type="checkbox"/> Actemra <input type="checkbox"/> Cosentyx <input type="checkbox"/> Cimzia <input type="checkbox"/> Enbrel <input type="checkbox"/> Humira <input type="checkbox"/> Kevzara <input type="checkbox"/> Orencia <input type="checkbox"/> Otezla			
Methotrexate Length of Treatment: _____ Reason for Discontinuing: _____	_____ Length of Treatment: _____ Reason for Discontinuing: _____		
_____ Length of Treatment: _____ Reason for Discontinuing: _____	_____ Length of Treatment: _____ Reason for Discontinuing: _____		
Additional Information: _____			

INSURANCE: PLEASE FAX BOTH SIDES OF PRESCRIPTION CARD AND MEDICAL CARD

PRESCRIPTION INFORMATION			QUANTITY	REFILLS
<input type="checkbox"/> Actemra®	<input type="checkbox"/> Pre-filled Syringe <input type="checkbox"/> Vials	<input type="checkbox"/> IV: Infuse _____ mg OR _____ mg/kg via IV every 4 weeks <input type="checkbox"/> SQ: Inject 162 mg SQ every other week <input type="checkbox"/> SQ: Inject 162 mg SQ every week	4 Week Supply	_____
<input type="checkbox"/> Acthar Gel	Please utilize manufacturer enrollment form and send to Longs			
<input type="checkbox"/> Cosentyx™	<input type="checkbox"/> SensorReady Pen <input type="checkbox"/> Prefilled Syringe	<input type="checkbox"/> INITIAL: Inject 150mg SQ on week 0,1,2,3, & 4 (Qty 5) <input type="checkbox"/> INITIAL: Inject 300mg SQ on week 0,1,2,3, & 4 (Qty 10)	<input type="checkbox"/> MAINTENANCE: Inject 150 mg SQ every 4 weeks (Qty 1) <input type="checkbox"/> MAINTENANCE: Inject 300 mg SQ every 4 weeks (Qty 2)	_____
<input type="checkbox"/> Cosentyx™ <i>Covered Until You're Covered</i>	<input type="checkbox"/> SensorReady Pen <input type="checkbox"/> Prefilled Syringe	<input type="checkbox"/> INITIAL: Inject 150mg SQ on week 0,1,2,3, & 4 (Qty 5) <input type="checkbox"/> INITIAL: Inject 300mg SQ on week 0,1,2,3, & 4 (Qty 10)	<input type="checkbox"/> MAINTENANCE: Inject 150 mg SQ every 4 weeks (Qty 1) <input type="checkbox"/> MAINTENANCE: Inject 300 mg SQ every 4 weeks (Qty 2)	_____
<input type="checkbox"/> Cimzia®	<input type="checkbox"/> Prefilled Syringe <input type="checkbox"/> Vials	<input type="checkbox"/> INITIAL: Inject 400 mg SQ at Day 0, Day 14, and Day 28 <input type="checkbox"/> MAINTENANCE: Inject 400 mg SQ every 4 weeks <input type="checkbox"/> MAINTENANCE: Inject 200 mg SQ every 2 weeks	1 Starter Kit 4 Week Supply	_____
<input type="checkbox"/> Enbrel®	<input type="checkbox"/> SureClick® Pen <input type="checkbox"/> Mini™ with AutoTouch™ <input type="checkbox"/> Prefilled Syringe <input type="checkbox"/> 25 mg <input type="checkbox"/> 50 mg <input type="checkbox"/> Vials 25 mg	<input type="checkbox"/> Inject 50 mg SQ every week <input type="checkbox"/> Inject 25 mg twice weekly 72-96 hours apart	4 Week Supply	_____
<input type="checkbox"/> Humira® <i>Citrate Free</i>	<input type="checkbox"/> Uveitis Starter Kit <input type="checkbox"/> Pen <input type="checkbox"/> Pre-filled Syringe	<input type="checkbox"/> UVEITIS INITIAL: Inject 80mg SQ on Day 1, 40mg on Day 8, then 40mg every other week <input type="checkbox"/> MAINTENANCE: Inject 40mg SQ every other week <input type="checkbox"/> MAINTENANCE: Inject 40mg SQ weekly	3 2 4	_____
<input type="checkbox"/> Humira®	<input type="checkbox"/> Uveitis Starter Kit <input type="checkbox"/> Pen <input type="checkbox"/> Pre-filled Syringe	<input type="checkbox"/> UVEITIS INITIAL: Inject 80mg SQ on Day 1, 40mg on Day 8, then 40mg every other week <input type="checkbox"/> MAINTENANCE: Inject 40mg SQ every other week <input type="checkbox"/> MAINTENANCE: Inject 40mg SQ weekly	4 2 4	_____
<input type="checkbox"/> Kevzara®	<input type="checkbox"/> Pen <input type="checkbox"/> 150 mg <input type="checkbox"/> 200 mg <input type="checkbox"/> Prefilled Syringe <input type="checkbox"/> 150 mg <input type="checkbox"/> 200 mg	<input type="checkbox"/> Inject 150 mg SQ every 2 weeks <input type="checkbox"/> Inject 200 mg SQ every 2 weeks	4 Week Supply	_____

Dispense As Written (no stamps) _____ Date _____ Substitution Permitted (no stamps) _____ Date _____

1. In order for a brand name product to be dispensed, the prescriber must write "Brand Necessary" or "Brand Medically Necessary" or any required state-specific language.
2. By signing this form, you are authorizing the pharmacy and its representatives to act on your behalf to obtain prior authorizations for the prescribed medication(s). We will also pursue available copay and financial assistance on behalf of your patients when available.
3. The pharmacy can only accept faxed prescriptions directly from a prescriber's office.
4. Prescribers must comply with any of their state-specific prescription requirements.