

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"/> Orenzia <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"/> Olumiant	2 mg Tablets	Take 2 mg by mouth once daily	30	_____
<input type="checkbox"/> Orenzia®	<input type="checkbox"/> 125mg PFS <input type="checkbox"/> 250mg Vials <input type="checkbox"/> 125mg Auto-Injector	<input type="checkbox"/> Inject 125mg SQ ONCE a week <input type="checkbox"/> Infuse _____mg at _____	4 Week Supply	_____
<input type="checkbox"/> Otezla®	<input type="checkbox"/> Starter Pack <input type="checkbox"/> 30mg Tablets	<input type="checkbox"/> Titrate: Take 1 tablet on day 1 then twice daily as directed OR date provided _____ <input type="checkbox"/> Maintenance: Take 1 tablet by mouth ONCE daily <input type="checkbox"/> Maintenance: Take 1 tablet by mouth TWICE daily.	1 Starter Pack 30 60	_____
<input type="checkbox"/> Otezla® <i>Bridge Rx</i>	30mg Tablets	<input type="checkbox"/> Bridge Rx: Take 1 tablet by mouth TWICE daily; dispensed by OSP (Recommended daily dose) ***Starter Pack Provided Date: _____ <input type="checkbox"/> Bridge Rx: Take 1 tablet by mouth ONCE daily; dispensed by OSP (For Patients with severe renal impairment)	28	_____
<input type="checkbox"/> Remicade®	100mg Vial	Infuse _____mg at _____	_____	_____
<input type="checkbox"/> Rinvoq™	Please utilize manufacturer enrollment form and send to Longs			
<input type="checkbox"/> Simponi®	<input type="checkbox"/> 50mg SmartJect or <input type="checkbox"/> PFS <input type="checkbox"/> Aria	<input type="checkbox"/> Inject 50mg SQ ONCE a MONTH as directed <input type="checkbox"/> Infuse _____mg at weeks 0 and 4, then every 8 weeks thereafter	4 Week Supply	_____
<input type="checkbox"/> Stelara®	<input type="checkbox"/> 45mg Prefilled Syringe <input type="checkbox"/> 90mg Prefilled Syringe Weight Required: _____	<input type="checkbox"/> Inject 45mg on day 0, then week 4, then every 12 weeks (Patients ≤ 220lbs) <input type="checkbox"/> Inject 90mg on day 0, then week 4, then every 12 weeks (Patients > 220lbs)	4 Week Supply	_____
<input type="checkbox"/> Taltz® <i>Psoriatic Arthritis Only</i>	<input type="checkbox"/> Auto Injector <input type="checkbox"/> Pre-filled Syringe	<input type="checkbox"/> Initial: Inject 160 mg SQ on week 0 <input type="checkbox"/> Maintenance: Inject 80 mg SQ every 4 weeks	2 1	_____
<input type="checkbox"/> Xeljanz®	<input type="checkbox"/> 5mg Tablets <input type="checkbox"/> 11mg XR Tablets	<input type="checkbox"/> Take 1 tablet by mouth TWICE daily <input type="checkbox"/> Take 1 tablet my mouth ONCE daily	60 30	_____
<input type="checkbox"/> Otrexup®			4 Week Supply	_____
<input type="checkbox"/> Rasuvo®			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.