

**Patient Information**

 Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex:  Male  Female SSN: \_\_\_\_\_ Wt (kg/lbs): \_\_\_\_\_ Ht (cm/in): \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_ Alternate: \_\_\_\_\_

Caregiver Name: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_ Phone: \_\_\_\_\_

Insurance Plan: \_\_\_\_\_ Plan ID: \_\_\_\_\_ BIN #: \_\_\_\_\_ PCN #: \_\_\_\_\_ GRP #: \_\_\_\_\_

**Please fax a copy of the front and back of the insurance card(s).**
**Prescriber + Shipping Information**

Prescriber Name: \_\_\_\_\_ DEA: \_\_\_\_\_ NPI: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Alternate: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

 If shipping to prescriber:  First Fill  Always  Never

**Clinical Information (Please fax all pertinent clinical and lab information)**
**Diagnosis:**  M06.9 (Rheumatoid Arthritis)  M08.0 (Juvenile Idiopathic Arthritis)  L40.59 (Psoriatic Arthritis)  L40.54 (Psoriatic Juvenile Arthritis)  M45.9 (Ankylosing Spondylitis)  \_\_\_\_\_

 Diagnosis Date: \_\_\_\_\_ TB Test:  Yes  No Negative Test Date: \_\_\_\_\_

Prior Therapy <input type="checkbox"/> Yes <input type="checkbox"/> No	Reason for Discontinuation of Therapy	Start Date	End Date

Comorbidities: \_\_\_\_\_

Concomitant Medications: \_\_\_\_\_

 Allergies:  NKDA  Other: \_\_\_\_\_

**Prescription**
**Directions, Quantity, Form**
**Refill**

<input type="checkbox"/> <b>Actemra®</b> (tocilizumab)	<input type="checkbox"/> Inject 162 mg subq every week <input type="checkbox"/> Inject 162 mg subq every other week <input type="checkbox"/>	<input type="checkbox"/> 4 x 162 mg/0.9mL <input type="checkbox"/> 2 x 162 mg/0.9mL <input type="checkbox"/>	<input type="checkbox"/> PFS <input type="checkbox"/> Vials	
<input type="checkbox"/> <b>Cimzia®</b> (certolizumab)	<input type="checkbox"/> Inject 400 mg subq at weeks 0, 2 and 4	<input type="checkbox"/> 6 x 200 mg/mL	<input type="checkbox"/> PFS <input type="checkbox"/> Vials	0
	<input type="checkbox"/> Inject 200 mg subq every 2 weeks <input type="checkbox"/> Inject 400 mg subq every 4 weeks	<input type="checkbox"/> 2 x 200 mg/mL	<input type="checkbox"/> PFS <input type="checkbox"/> Vials	
<input type="checkbox"/> <b>Cosentyx®</b> (secukinumab)	<input type="checkbox"/> Inject 150 mg subq once weekly at weeks 0, 1, 2 and 3	<input type="checkbox"/> 4 x 150 mg/mL	<input type="checkbox"/> Sensoready® Pen	0
	<input type="checkbox"/> Inject 300 mg subq once weekly at weeks 0, 1, 2 and 3	<input type="checkbox"/> 8 X 150 mg/mL	<input type="checkbox"/> PFS	
	<input type="checkbox"/> Inject 150 mg subq on day 29 and every 4 weeks thereafter <input type="checkbox"/> Inject 300 mg subq on day 29 and every 4 weeks thereafter	<input type="checkbox"/> 1 x 150 mg/mL <input type="checkbox"/> 2 x 150 mg/mL	<input type="checkbox"/> Sensoready® Pen <input type="checkbox"/> PFS	
<input type="checkbox"/> <b>Enbrel®</b> (etanercept)	<input type="checkbox"/> Inject 50 mg subq every week	<input type="checkbox"/> 4 x 50 mg/mL	<input type="checkbox"/> SureClick® Autoinjector	
	<input type="checkbox"/> Inject _____ mg (0.8 mg/kg x _____ kg) subq every week	<input type="checkbox"/> _____ x 25 mg/mL	<input type="checkbox"/> PFS <input type="checkbox"/> Vials	
<input type="checkbox"/> <b>Humira®</b> (adalimumab) <i>Adults &amp; Pediatrics Age ≥ 2 years</i>	<input type="checkbox"/> Inject 10 mg subq every other week (10 to <15 kg)	<input type="checkbox"/> 2 x 10 mg/0.2mL	<input type="checkbox"/> PFS	
	<input type="checkbox"/> Inject 20 mg subq every other week (15 to <30 kg)	<input type="checkbox"/> 2 x 20 mg/0.4mL		
	<input type="checkbox"/> Inject 40 mg subq every other week (≥30 kg)	<input type="checkbox"/> 2 x 40 mg/0.8mL	<input type="checkbox"/> Pens	
	<input type="checkbox"/> Inject 40 mg subq once weekly	<input type="checkbox"/> 4 x 40 mg/0.8mL	<input type="checkbox"/> PFS	
<input type="checkbox"/> <b>Inflectra®</b> (infliximab) <input type="checkbox"/> <b>Remicade®</b> (infliximab) <input type="checkbox"/> <b>Renflexis®</b> (infliximab)	<input type="checkbox"/> Inject _____ mg (5mg/kg x _____ kg) IV at 0, 2, and 6 weeks, then every _____ weeks thereafter			
	<input type="checkbox"/> In conjunction with Methotrexate: Inject _____ mg (3mg/kg x _____ kg) IV at 0, 2, and 6 weeks, then every _____ weeks thereafter			

Prescription	Directions, Quantity, Form		Refill
<input type="checkbox"/> <b>Krystexxa®</b> (pegloticase injection) 8mg/mL	<input type="checkbox"/> Inject 8mg via intravenous infusion every 2 weeks		
<input type="checkbox"/> <b>Methotrexate®</b>	<input type="checkbox"/> Take _____ tablet(s) by mouth every week <input type="checkbox"/> Inject _____ mL subq every 7 days at the same time each week		<input type="checkbox"/> 2.5mg Tablets <input type="checkbox"/> 25mg/mL Injectable Solution
<input type="checkbox"/> <b>Orencia®</b> (abatacept)	<input type="checkbox"/> Infuse _____ mg at week 0 <b>only</b> <input type="checkbox"/> Infuse _____ mg at weeks 0 and 2		<input type="checkbox"/> _____ x 250 mg <input type="checkbox"/> Vials 0
	<i>(JIA &lt;75 kg: 10 mg/kg; JIA ≥75 kg or RA: &lt;60 kg: 500 mg, 60-100 kg: 750 mg; &gt;100 kg: 1000 mg)</i>		
	<input type="checkbox"/> Infuse _____ mg at week 4 and every 4 weeks thereafter		<input type="checkbox"/> _____ x 250 mg <input type="checkbox"/> Vials
<i>(JIA &lt;75 kg: 10 mg/kg; JIA ≥75 kg or RA: &lt;60 kg: 500 mg, 60-100 kg: 750 mg; &gt;100 kg: 1000 mg)</i>			
	<input type="checkbox"/> Inject 125 mg subq once weekly		<input type="checkbox"/> 4 x 125 mg/mL <input type="checkbox"/> PFS <input type="checkbox"/> ClickJect™
<input type="checkbox"/> <b>Otezla®</b> (apremilast)	<input type="checkbox"/> Take as directed per package instructions		<input type="checkbox"/> 55 tablets <input type="checkbox"/> 28-day starter pack 0
	<input type="checkbox"/> Take 30 mg twice daily by mouth <input type="checkbox"/>		<input type="checkbox"/> 60 x 30 mg tablets <input type="checkbox"/>
<input type="checkbox"/> <b>Otrexup®</b> (methotrexate)	<input type="checkbox"/> Inject _____ mL subq every week		<input type="checkbox"/> 10mg Auto injector <input type="checkbox"/> 15mg Auto injector <input type="checkbox"/> 20mg Auto injector <input type="checkbox"/> 25mg Auto injector <input type="checkbox"/> 12.5mg Auto injector <input type="checkbox"/> 17.5mg Auto injector <input type="checkbox"/> 22.5mg Auto injector
<input type="checkbox"/> <b>Rasuvo®</b> (methotrexate)	<input type="checkbox"/> Inject _____ mL subq every week		<input type="checkbox"/> 7.5mg Auto injector <input type="checkbox"/> 12.5mg Auto injector <input type="checkbox"/> 17.5mg Auto injector <input type="checkbox"/> 22.5mg Auto injector <input type="checkbox"/> 27.5mg Auto injector <input type="checkbox"/> 10mg Auto injector <input type="checkbox"/> 15mg Auto injector <input type="checkbox"/> 20mg Auto injector <input type="checkbox"/> 25mg Auto injector <input type="checkbox"/> 30mg Auto injector
<input type="checkbox"/> <b>Simponi®</b> (golimumab)	<input type="checkbox"/> Inject 50 mg subq once a month		<input type="checkbox"/> 1 x 50 mg/0.5mL <input type="checkbox"/> SmartJect® Autoinjector <input type="checkbox"/> PFS
<input type="checkbox"/> <b>Simponi Aria®</b> (golimumab)	<input type="checkbox"/> Infuse _____ mg (2 mg/kg x _____ kg) over 30 minutes at weeks 0		<input type="checkbox"/> _____ x 50 mg/4ml <input type="checkbox"/> Vials 0
	<input type="checkbox"/> Infuse _____ mg (2 mg/kg x _____ kg) over 3 minutes at week 4 and every 8 weeks thereafter		<input type="checkbox"/> _____ x 50 mg/4ml <input type="checkbox"/> Vials
<input type="checkbox"/> <b>Stelara®</b> (ustekinumab)	<input type="checkbox"/> Inject 45 mg subq on Day 1 (≤100 kg)		<input type="checkbox"/> 1 x 45 mg/0.5mL <input type="checkbox"/> PFS 0
	<input type="checkbox"/> Inject 90 mg subq on Day 1 (>100 kg)		<input type="checkbox"/> 1 x 90 mg/mL <input type="checkbox"/> PFS
	<input type="checkbox"/> Inject 45 mg subq on Day 29 and every 12 weeks thereafter (≤100 kg)		<input type="checkbox"/> 1 x 45 mg/0.5mL <input type="checkbox"/> PFS
	<input type="checkbox"/> Inject 90 mg subq on Day 29 and every 12 weeks thereafter (>100 kg)		<input type="checkbox"/> 1 x 90 mg/mL <input type="checkbox"/> PFS
Patient eligible for self administration: <input type="checkbox"/> Yes <input type="checkbox"/> No _____			
<input type="checkbox"/> <b>Xeljanz®</b> (tofacitinib)	<input type="checkbox"/> Take 5 mg by mouth twice daily <input type="checkbox"/>		<input type="checkbox"/> 60 x 5 mg tablets <input type="checkbox"/>
<input type="checkbox"/> <b>Xeljanz®XR</b> (tofacitinib)	<input type="checkbox"/> Take 11 mg by mouth once daily		<input type="checkbox"/> 30 x 11 mg tablets

 Injection Training Provided by:  Prescriber's Office  Pharmacy  Other: \_\_\_\_\_

Per state-specific law, prescriptions will be dispensed as generic, if applicable, unless notated otherwise: \_\_\_\_\_

Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I authorize AmeriPharma and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time by providing written notice to AmeriPharma.

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