ahma (rx) RHEUMATOLOGY

Toll free phone: 844.749.6628
Toll free fax: 855.516.3880

Patient Information – Please attach a copy of the patient's insurance card

Patient Name:		Date of Birth:	☐ Male ☐ Female
Address:	City:	State:	Zip:
Phone Number:	Alternate Phone Number:	Language:	
Allergies (Required): ☐ NKDA	Height:	Weight:	SSN:

Product Shipping Options: ☐ Patient's Home ☐ Prescriber O˜ice ☐ Alternative Address:

Prescriber Information

Practice Name:		O˜ice Contact:	
Prescriber :		NPI:	DEA:
Practice Address:	City:	State:	Zip:
Phone Number:	Fax Number:		

Clinical Information – *Please send all available chart notes including lab results*

Diagnosis/ICD -10: Fracture history: Site: Date: Site: Date:

Prior Failed Medications: ☐ Methotrexate ☐ Other:_____ Length of treatment: Reason for discontinuing:

Does the patient have hepatic impairment? ☐ Yes ☐ No ANC Score: _____/mm^3 Platelet count: _____ /mm^3

Does the patient have a latex allergy? ☐ Yes ☐ No TB/PPD test given/intended to be given before start? ☐ Yes ☐ No ****Please send documentation****

Is Hepatitis B ruled out? ☐ Yes ☐ No If no, has treatment started? ☐ Yes ☐ No

Prescription Information

Medication	Dose	Directions	Quantity	Refills
☐ Actemra®	162 mg prefilled syringe	Inject 162 mg Sub -Q: ☐ Once a week (> 100 kg) – OR – ☐ Every other week (< 100 kg)	☐ 2 PFS ☐ 4 PFS	
☐ Benlysta®	☐ 200 mg prefilled syringe ☐ 200 mg autoinjector	Inject 200 mg Sub-Q once weekly	4 PFS	
☐ Cimzia®	☐ 200 x 2 prefilled syringe	Initial: ☐ inject 400 mg Sub-Q at week 0, 2, and 4 Maintenance: ☐ Inject 400 mg Sub-Q once every 4 weeks OR ☐ Inject 200 mg Sub-Q once every 2 weeks	1 starter pack 1 kit	0
☐ Cosentyx®	☐ 150 mg/mL Sensoready® pen ☐ 150 mg/mL prefilled syringe	With a loading dose: ☐ Inject 150 mg Sub -Q at week 0, 1, 2, 3, and 4 then every 4 weeks thereafter Without a loading dose: ☐ Inject 150 mg Sub -Q every 4 weeks	4 PFS/pens 1 PFS/pen	
☐ Enbrel®	☐ 25 mg powder vial ☐ 25 mg prefilled syringe ☐ 50 mg SureClick™ ☐ 50 mg prefilled syringe	☐ Inject 50 mg Sub-Q once a week ☐ Inject ____ mg Sub -Q once a week (0.8 mg/kg)	☐ 4 PFS/pens	
☐ Humira®	☐ 40 mg pen ☐ 40 mg prefilled syringe	☐ Inject 40 mg Sub-Q every other week ☐ Inject 40 mg Sub-Q once a week	☐ 2 PFS/pens ☐ 4 PFS/pens	
☐ Kevzara®	☐ 200 mg prefilled syringe ☐ 150 mg prefilled syringe	☐ Inject 200 mg Sub-Q once every other week ☐ Inject 150 mg Sub -Q once every other week	2 PFS	
☐ Orencia®	☐ ___ mg prefilled syringe ☐ 125 mg prefilled syringe ☐ 125 mg autoinjector	Inject _____ mg Sub-Q once a week (weight-based dosing)	4 PFS	
☐ Otezla®	☐ Starter pack ☐ Bridge Pack ☐ 30 mg tablets	☐ Titration: take 1 tablet on day 1, then twice daily as directed ☐ Take 30 mg by mouth once daily ☐ Take 30 mg by mouth twice daily ☐ Take 1 tablet by mouth twice daily ***(Titration date: ___ /___ /_____)***	1 starter pack 28 tablets 60 tablets	0
☐ Simponi®	☐ 50 mg SmartJect® ☐ 50 mg prefilled syringe	Inject 50 mg Sub-Q once a month as directed	1 PFS	
☐ Stelara®	☐ 45 mg prefilled syringe (< 100 kg) ☐ 90 mg prefilled syringe (>100 kg)	Inject contents of 1 syringe Sub -Q initially and 4 weeks later, and then every 12 weeks	1 PFS	
☐ Xeljanz®	5 mg tablets	Take 1 tablet by mouth twice daily	60 tablets	
☐ Xeljanz® XR	11 mg tablets	Take 1 tablet by mouth daily with or without food	30 tablets	
☐ Other:				

PRESCRIBER SIGNATURE (PLEASE SIGN AND DATE BELOW)

***Prescriber Authorization:** I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms, the receipt and submission of patient lab values and other patient data including pursuing available copay and financial assistance on behalf of my patients. If this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

☐ Product substitution permitted ☐ Dispense as Written

Prescriber Signature: _____ _____

Date

urac ACCREDITED Specialty Pharmacy