



RHEUMATOID ARTHRITIS SPECIALTY CARE PROGRAM

Phone: **844-284-4578** • Fax: **844-823-5658**



1 PATIENT INFORMATION:

Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone: _____ Alt. Phone: _____
 Email: _____
 DOB: _____ Gender: M F Caregiver: _____
 Height: _____ Weight: _____ Allergies: _____

2 PRESCRIBER INFORMATION:

Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone: _____ Fax: _____
 NPI: _____ DEA: _____
 Tax I.D.: _____
 Office Contact: _____ Phone: _____

3 STATEMENT OF MEDICAL NECESSITY: (Please Attach All Medical Documentation)

Date of Diagnosis: _____ Patient also taking Methotrexate? Yes No
 ICD-10: _____ Serious or active infection present? Yes No
 Other: _____ Hep B ruled out or treatment started? Yes No
 TB Test: Positive Negative Date: _____ Does patient have latex allergy? Yes No
 LFT: ALT: _____ AST: _____ Date: _____

If Prior Authorization is Denied:
 Automatically Draft Appeal for Review
 Send Preferred Formulary Alternatives

Prior Failed Treatments:	Indicate Drug Name and Length of Treatment:
<input type="checkbox"/> Azulfidine®	_____
<input type="checkbox"/> Biologics	_____
<input type="checkbox"/> Calcipotriene	_____
<input type="checkbox"/> Celebrex®	_____
<input type="checkbox"/> Corticosteroids	_____
<input type="checkbox"/> Indocin®	_____
<input type="checkbox"/> Methotrexate	_____
<input type="checkbox"/> Others	_____

4 INJECTION TRAINING: Pharmacist to Provide Training Patient Trained in MD Office Manufacturer Nurse Support

5 PRODUCT DELIVERY: Patient's Home Physician's Office Pharmacy to Coordinate

6 INSURANCE INFORMATION: Please Include Front and Back Copies of Pharmacy and Medical Card

7 PRESCRIPTION INFORMATION: (Please be sure to choose both induction and maintenance dose where applicable)

Patient Name: _____

Medication	Dosage & Strength	Direction	QTY	Refills
<input type="checkbox"/> ACTEMRA®	<input type="checkbox"/> 162mg/0.9ml Prefilled Syringe	<input type="checkbox"/> Inject 162mg SC every other week (< 220 lbs) <input type="checkbox"/> Inject 162mg SC every week (> 220 lbs)		
<input type="checkbox"/> CIMZIA®	<input type="checkbox"/> Prefilled Syringe Starter Kit <input type="checkbox"/> 200mg/ml Prefilled Syringe <input type="checkbox"/> 200mg Lyophilized Powder Vial	<input type="checkbox"/> Induction Dose: Inject 400mg SC on day 1, day 14 and day 28 <input type="checkbox"/> Maintenance: Inject 400mg SC every 4 weeks <input type="checkbox"/> Maintenance: Inject 200mg SC every other week	6 2	0
<input type="checkbox"/> ENBREL®	<input type="checkbox"/> 50mg/ml Sureclick Autoinjector <input type="checkbox"/> 50mg/ml Prefilled Syringe <input type="checkbox"/> 25mg/ml Prefilled Syringe <input type="checkbox"/> 25mg/ml Vial	<input type="checkbox"/> Inject 50mg SC once a week <input type="checkbox"/> Inject 25mg SC twice a week (3-4 days apart) <input type="checkbox"/> Other _____		
<input type="checkbox"/> HUMIRA®	<input type="checkbox"/> 40mg/0.8ml Pen <input type="checkbox"/> 40mg/0.8ml Prefilled Syringe <input type="checkbox"/> Patient has signed HUMIRA Complete form	<input type="checkbox"/> Inject 40mg SC every other week <input type="checkbox"/> Inject 40mg SC once a week		
<input type="checkbox"/> ORENCIA®	<input type="checkbox"/> 250mg Lyophilized Powder Vial <input type="checkbox"/> 125mg/ml ClickJect Autoinjector <input type="checkbox"/> 125mg/ml Prefilled Syringe	<input type="checkbox"/> Induction Dose: Patient Weight < 132 lbs: 500mg; 132-220 lbs: 750mg; > 220 lbs: 1000mg administered IV, then inject 125mg SC within 24 hours <input type="checkbox"/> Inject 125mg SC once a week	4	0
<input type="checkbox"/> OTEZLA® (for PsA)	<input type="checkbox"/> Starter Pack (Titration) <input type="checkbox"/> 30mg Tablets	<input type="checkbox"/> Starter Pack: Take one tablet in the morning on day 1, then take one tablet in the morning and one tablet in the evening as directed on the starter pack <input type="checkbox"/> Maintenance: Take one 30mg tablet by mouth twice daily	1 60	0
<input type="checkbox"/> RASUVO®	<input type="checkbox"/> _____	<input type="checkbox"/> _____		
<input type="checkbox"/> SIMPONI®	<input type="checkbox"/> 50mg/0.5ml Smartject Autoinjector <input type="checkbox"/> 50mg/0.5ml Prefilled Syringe	<input type="checkbox"/> Inject 50mg SC once a month	1	
<input type="checkbox"/> STELARA® (for PsA)	<input type="checkbox"/> 45mg/0.5ml Prefilled Syringe (for < 220 lbs) <input type="checkbox"/> 90mg/1ml Prefilled Syringe (for > 220 lbs) <input type="checkbox"/> Yes or <input type="checkbox"/> No: STELARA SELF-INJECTION: Healthcare provider certifies that patient has been trained and is eligible for self-injection	<input type="checkbox"/> Induction Dose: Inject 1 prefilled syringe SC on day 1 <input type="checkbox"/> Maintenance: Inject 1 prefilled syringe SC on day 29, and every 12 weeks thereafter	1 1	0
<input type="checkbox"/> XELJANZ®	<input type="checkbox"/> 5mg Tablet	<input type="checkbox"/> Take one 5mg tablet by mouth twice a day	60	
<input type="checkbox"/> XELJANZ® XR	<input type="checkbox"/> 11mg Tablet	<input type="checkbox"/> Take one 11mg tablet once a day	30	
<input type="checkbox"/> _____	_____	_____		

8 PRESCRIBER SIGNATURE: I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs.

Signature: _____ Date: _____ Signature: _____ Date: _____

Substitution Permitted

Dispense As Written

Prior authorization approval and insurance benefits will be determined by the payor based upon the patient's eligibility, medical necessity, and the terms of the patient's coverage, among other things. Participation in this program is not a guarantee of prior authorization or of payment.

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