1960 Pharmacy
Your safety net for healthcare

RHEUMATOLOGY

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1 PATIENT INFORMATION

(Complete the following or include demographic sheet)

Patient Name: _____
Address: _____
City, State, Zip: _____
Primary Phone: _____ ☐Home ☐Cell ☐Work
Alternate Phone: _____ ☐Home ☐Cell ☐Work
DOB: _____ Gender: ☐Male ☐Female
E-mail: _____
Last Four of SS #: _____ Primary Language: _____

2 PRESCRIPTION INFORMATION

Prescriber's Name: _____
State License #: _____ NPI # _____
DEA #: _____
Group or Hospital: _____
Address: _____
City, State, Zip: _____
Phone: _____ Fax: _____
Contact Person: _____ Phone: _____

3 INSURANCE INFORMATION

Please fax copy of prescription and insurance cards with this form, if available (front and back)

Insurance: ❑ Medicare ❑ Medicaid ❑ Commercial_____

ID _____ BIN_____ PCN _____ GROUP_____

4 DIAGNOSIS AND CLINICAL INFORMATION

Diagnosis: ❑ Rheumatoid Arthritis ❑ Ankylosing Spondylitis ❑ Osteoporosis ❑ Psoriatic Arthritis ❑ Lupus ❑ Gout ❑ Spondyloarthropathy ❑ Uveitis Date of Diagnosis: _____

Prior Treatment: ❑ **Humira** ❑ **Enbrel** ❑ **Stelara** ❑ **Others:**_____ **TB Test:** ❑ **Positive** ❑ **Negative**

5 PRESCRIPTION INFORMATION

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Actemra®	☐ 162mg/0.9 mL Prefilled Syringe	☐ Patients less than 100 kg weight 162 mg administered subcutaneously every other week followed by an increase to every week based on clinical response ☐ Patients at or above 100 kg weight 162 mg administered subcutaneously every week		
☐ Cimzia®	☐ Cimzia Starter Kit	☐ Induction dose: inject 400mg subcutaneously on day 1, at week 2, and at week 4	1 kit (6 prefilled syringes)	0
	☐ 200mg/1 mL Prefilled Syringe ☐ 200mg vial	☐ Maint. Dose: Inject 200mg subcutaneously every OTHER week. ☐ Maint. Dose: Inject 400mg subcutaneously every 4 weeks. ☐ Other: _____		
☐ Enbrel®*	☐ 50mg/ml Sureclick™ Autoinjector ☐ 50mg/ml Prefilled Syringe ☐ 25mg/0.5ml Prefilled Syringe ☐ 25mg Vial	☐ Inject 50mg subcutaneously ONCE a week. ☐ Inject 25mg subcutaneously TWICE a week (72-96 hours apart). ☐ Other:_____		
☐ Humira®*	☐ 40mg/0.8ml Pen ☐ 40mg/0.8ml Prefilled Syringe ☐ 80mg/0.8ml Pen	☐ Inject 40mg subcutaneously every OTHER week. ☐ Inject 20mg subcutaneously every OTHER week. ☐ Other:_____		
☐ Otezla®*	☐ Starter Pack ☐ 30mg tablet ☐	☐ Titrate: Take 1 tablet on day 1then twice daily as directed OR date provided_____ ☐ Maintenance: Take 1 tablet by mouth twice daily. ☐ Bridge RX: Take 1 tablet by mouth twice daily; disp. by OSP.		
☐ Simponi®	☐ 50mg/0.5ml Prefilled SmartJect Autoinjector ☐ 50mg/0.5ml Prefilled Syringe	☐ Inject 50mg (0.5ml) subcutaneously once a month ☐ Other:_____		
☐ Stelara®	☐ Injection 45 mg/0.5 mL in a single-use prefilled syringe ☐ Injection: 90 mg/mL in a single-use prefilled syringe	☐ The recommended dose is 45 mg SQ initially and 4 weeks later, followed by 45 mg SQ every 12 weeks. For patients with co-existent moderate-to-severe plaque psoriasis weighing>100kg (220 lbs), the recommended dose is 90 mg initially and 4 weeks later, followed by 90 mg every 12 weeks.		
☐ Xeljanz®	☐ Oral: 5mg	☐ Take 5mg PO Twice a day.		
☐ Xeljanz XR®	☐ Oral: 11mg	☐ Take 11mg PO Once daily.		
☐ Other				

STAMP SIGNATURE NOT ALLOWED

☐ Patient is interested in patient assistance programs

☐ Ancillary supplies and kits provided as needed for administration

PHYSICIAN SIGNATURE REQUIRED

X _____ (Date)
DISPENSE AS WRITTEN

X _____ (Date)
PRODUCT SUBSTITUTION PERMITTED

By signing this form and utilizing our services,you are authorising 1960 Pharmacy and it's employers to serve as your prior authorization designed agent in dealing with medical prescription insurance companies