



RHEUMATOID ARTHRITIS SPECIALTY CARE PROGRAM

Phone: **844-378-3784** • Fax: **888-972-7058**



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: _____
 Supervising Physician: _____ NPI: _____
 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
 Does patient have latex allergy? Yes No
 TB Test: Positive Negative Date: _____ LFT: ALT: _____ AST: _____ Date: _____

Prior Failed Treatments:

- Azulfidine® Celebrex® Methotrexate
 Biologics Corticosteroids Others
 Calcipotriene Indocin®

Indicate Drug Name and Length of Treatment:

If Prior Authorization is denied, recommended formulary alternatives will be provided to the prescriber based upon the patient's insurance coverage.

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

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

Patient Name: _____ Patient's Date of Birth: _____

Medication	Dosage & Strength	Direction	QTY	Refills
<input type="checkbox"/> ACTEMRA®	<input type="checkbox"/> 162mg/0.9ml Prefilled Syringe <input type="checkbox"/> 162mg/0.9ml Prefilled Autoinjector (ACTPen™)	<input type="checkbox"/> <220 lbs: Inject 162mg SC every other week, followed by an increase to every week based on clinical response <input type="checkbox"/> ≥220 lbs: Inject 162mg SC every week		
<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"/> COLCIGEL®	<input type="checkbox"/> _____	<input type="checkbox"/> _____		
<input type="checkbox"/> COSENTYX® (for PsA)	<input type="checkbox"/> 150mg/ml Sensoready® Pen <input type="checkbox"/> 150mg/ml Prefilled Syringe <input type="checkbox"/> 150mg/ml Lyophilized Powder Vial	<input type="checkbox"/> Induction Dose: Inject 150mg SC at weeks 0, 1, 2, 3, and 4 <input type="checkbox"/> Induction Dose: Inject 300mg SC at weeks 0, 1, 2, 3, and 4 <input type="checkbox"/> Maintenance Dose: Inject 150mg SC every four weeks <input type="checkbox"/> Maintenance Dose: Inject 300mg SC every four weeks	5 10 1 2	0 0
<input type="checkbox"/> ENBREL®	<input type="checkbox"/> 50mg/ml SureClick® Autoinjector <input type="checkbox"/> 50mg/ml Enbrel Mini® Prefilled Cartridge For Enbrel Mini® only: AutoTouch® Autoinjector <input type="checkbox"/> 50mg/ml Prefilled Syringe <input type="checkbox"/> 25mg/0.5ml Prefilled Syringe <input type="checkbox"/> 25mg/ml Vial	<input type="checkbox"/> Inject 50mg SC once a week		
<input type="checkbox"/> HUMIRA®	<input type="checkbox"/> 40mg/0.4ml Pen <input type="checkbox"/> 40mg/0.4ml Prefilled Syringe <input type="checkbox"/> 80mg/0.8ml Pen <i>All strengths and dosages listed are Humira® Citrate Free</i>	<input type="checkbox"/> Inject 40mg SC every other week <input type="checkbox"/> Inject 40mg SC once a week <input type="checkbox"/> Inject 80mg SC every other week		
<input type="checkbox"/> KEVZARA®	<input type="checkbox"/> 150mg/1.14ml Prefilled Syringe <input type="checkbox"/> 150mg/1.14ml Prefilled Pen <input type="checkbox"/> 200mg/1.14ml Prefilled Syringe <input type="checkbox"/> 200mg/1.14ml Prefilled Pen	<input type="checkbox"/> Inject 150mg SC every 2 weeks <input type="checkbox"/> Inject 200mg SC every 2 weeks	2 2	
<input type="checkbox"/> OLUMIANT®	<input type="checkbox"/> 2mg Tablet <input type="checkbox"/> 1mg Tablet	<input type="checkbox"/> Take one 2mg tablet by mouth with or without food daily <input type="checkbox"/> Moderate Renal Impairment: Take one 1mg tablet by mouth with or without food daily	30 30	
<input type="checkbox"/> ORENCIA®	<input type="checkbox"/> 125mg/ml Prefilled Syringe <input type="checkbox"/> 125mg/ml ClickJect™ Autoinjector <input type="checkbox"/> 250mg Lyophilized Powder Vial	<input type="checkbox"/> Induction Dose: <input type="checkbox"/> <60 kg: 500mg administered IV, then inject 125mg SC within 24 hours <input type="checkbox"/> 60 to 100 kg: 750mg administered IV, then inject 125mg SC within 24 hours <input type="checkbox"/> >100 kg: 1000mg administered IV, then inject 125mg SC within 24 hours <input type="checkbox"/> Inject 125mg SC once a week		
<input type="checkbox"/> _____				

Otezla®, Rasuvo®, Rinvoq™, Simponi®, Stelara®, Tremfya™, Xeljanz® and Xeljanz®XR are listed alphabetically on respective enrollment forms.

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.

Confidentiality Notice: This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the named addressee, you should not disseminate, distribute or copy this fax. Please inform the sender immediately if you have received this document in error and then destroy this document immediately.



RHEUMATOID ARTHRITIS SPECIALTY CARE PROGRAM

Phone: **844-378-3784** • Fax: **888-972-7058**



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: _____
 Supervising Physician: _____ NPI: _____
 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
 Does patient have latex allergy? Yes No
 TB Test: Positive Negative Date: _____ LFT: ALT: _____ AST: _____ Date: _____

Prior Failed Treatments:

- Azulfidine® Celebrex® Methotrexate
 Biologics Corticosteroids Others
 Calcipotriene Indocin®

Indicate Drug Name and Length of Treatment:

If Prior Authorization is denied, recommended formulary alternatives will be provided to the prescriber based upon the patient's insurance coverage.

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

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

Patient Name: _____ Patient's Date of Birth: _____

Medication	Dosage & Strength	Direction	QTY	Refills
<input type="checkbox"/> OTEZLA® (for PsA)	<input type="checkbox"/> Two-week Starter Pack (Titration) <input type="checkbox"/> 28-day 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 <i>*For patients with severe renal impairment take one 30mg tablet once daily and skip afternoon doses in Starter Pack</i>	1 60	0
<input type="checkbox"/> RASUVO®	Single-dose auto-injector prefilled syringe: <input type="checkbox"/> 7.5mg <input type="checkbox"/> 10mg <input type="checkbox"/> 12.5mg <input type="checkbox"/> 15mg <input type="checkbox"/> 17.5mg <input type="checkbox"/> 20mg <input type="checkbox"/> 22.5mg <input type="checkbox"/> 25mg <input type="checkbox"/> 30mg	<input type="checkbox"/> Inject 7.5 mg every week as directed		
<input type="checkbox"/> RINVOQ™	<input type="checkbox"/> 15mg Extended-Release Tablets	<input type="checkbox"/> Take one 15mg tablet once a day	30	
<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 <input type="checkbox"/> 45mg/0.5ml Vial <input type="checkbox"/> 90mg/1ml Prefilled Syringe	<input type="checkbox"/> Induction Dose: Inject 45mg SC on day 1	1	
		<input type="checkbox"/> Maintenance: Inject 45mg SC on day 29, and every 12 weeks thereafter	1	
<input type="checkbox"/> STELARA® (for PsA)	<input type="checkbox"/> 45mg/0.5ml Prefilled Syringe <input type="checkbox"/> 45mg/0.5ml Vial <input type="checkbox"/> 90mg/1ml Prefilled Syringe	<input type="checkbox"/> PsA with Coexistent Moderate-to-Severe Plaque Psoriasis (>220 lbs) <input type="checkbox"/> Induction Dose: Inject 90 SC on day 1	1	
		<input type="checkbox"/> Maintenance: Inject 90mg SC on day 29, and every 12 weeks thereafter	1	
<input type="checkbox"/> Yes or <input type="checkbox"/> No: <i>STELARA SELF-INJECTION: Healthcare provider certifies that patient has been trained and is eligible for self-injection</i>				
<input type="checkbox"/> TREMFYA® (for PsA)	<input type="checkbox"/> 100mg/ml Prefilled Syringe <input type="checkbox"/> 100mg/ml One-Press Patient Controlled Injector	<input type="checkbox"/> Induction Dose: Inject 100mg/ml SC at weeks 0 and 4 <input type="checkbox"/> Maintenance: Inject 100mg/ml SC every 8 weeks thereafter	2 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 <i>*For patients with moderate renal or hepatic impairment take one 5mg tablet once daily</i>	30	
<input type="checkbox"/> _____				

Actemra®, Cimzia®, Colcigel®, Enbrel®, Humira®, Kevzara®, Olumiant® and Orencia® are listed alphabetically on respective enrollment forms.

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.

Confidentiality Notice: This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the named addressee, you should not disseminate, distribute or copy this fax. Please inform the sender immediately if you have received this document in error and then destroy this document immediately.