For assistance, contact your pharmacy representative: ______________________ Phone:______________________ **(For providers only)**

PLEASE CONSIDER SENDING YOUR PRESCRIPTION ELECTRONICALLY. ALL OF OUR PHARMACY LOCATIONS ACCEPT ELECTRONIC PRESCRIPTIONS.

Note: This form is intended for prescriber use only, if faxed, the fax must come from MD office or hospital **(may not be faxed by patient)**.

Walgreens | allianceRx Walgreens + PRIME

Rheumatology

Prescription/Pharmacy Intake Form

☐Central Pharmacy: ______________________

☐Retail/Community Pharmacy Fax: ______________________ Pharmacy Phone: ______________________

Date Needed: ____________ **Ship To:** ☐Prescriber's Office ☐Patient's Home ☐Other: ______________________

PATIENT INFORMATION

Patient name: ______________________ DOB: ____________ ☐Male ☐Female

Address: ______________________ City: ____________ State: ______ Zip code: ____________

Phone # (Daytime): ______________________ Phone # (Evening): ______________________

E-mail Address: ______________________ Case Manager: ______________________

Insurance provider **(Please include copy of front and back of card)**: ______________________

ID #: ____________ Policy/Group #: ____________ Phone #: ____________ ☐Patient is eligible for Medicare

Name of Insured: ______________________ Employer: ______________________

Relationship to Patient: ☐Self ☐Other: ____________ Prescription Card: ☐Yes ☐No Carrier: ____________ Policy/Group #: ____________

Will there be access to anaphylactic medications and oxygen at the administration site? ______________________

CLINICAL ASSESSMENT – Please complete ALL sections to avoid delays in filling prescription

☐Patient is new to therapy ☐Patient is currently on therapy Start date: ____________ ☐Physician Provides Injection Training Injection/Infusion Date: ____________

Primary Diagnosis Code and Condition (ICD-10): ______________________ Other Diagnosis/Conditions: ______________________

Joints Affected: ______ Number of Tender Joints: ______ Number of Swollen Joints: ______ Current Weight: ____________ Date: ____________

☐New Therapy Induction ☐Therapy Change ☐Therapy Continuation | Weeks Completed ☐0 ☐2 ☐4 ☐6 | Stop Date: ______________________

ESR: ______ Date: ____________ CRP: ______ Date: ____________ TB Results: ____________ Date: ____________

Allergies: ______________________

MEDICATION

Actemra (tocilizumab)
☐162mg ☐Syringe ☐Autoinjector
☐80mg/4mL Vial
☐200mg/10mL Vial
☐400mg/20mL Vial
Directions: ____________ Quantity: ___ Refills: ______

Benlysta (belimumab)
☐200mg ☐Syringe☐Autoinjector
☐120mg vial
☐400mg vial
Directions: ____________ Quantity: ___ Refills: ______

Cimzia (certolizumab pegol)
☐(6) 200mg starter kit
Directions: ____________ Quantity: ___ Refills: ______
☐(2) 200mg ☐Syringe ☐Vial
Directions: ____________ Quantity: ___ Refills: ______

Cosentyx (secukinumab)
☐150mg ☐Pen ☐Prefilled Syringe
☐2X150mg Pack (300mg) ☐Pen ☐Prefilled Syringe
Directions: ____________ Quantity: ___ Refills: ______

Enbrel (etanercept)
☐25mg ☐Syringe ☐Vial
☐50mg ☐Syringe ☐SureClick™ Pen ☐Mini™ Cartridge
Directions: ____________ Quantity: ___ Refills: ______

Humira (adalimumab)
☐10mg/0.2ml Prefilled Syringe Pediatric
☐20mg/0.4ml Prefilled Syringe Pediatric
☐40mg/0.8ml ☐Pen ☐Prefilled Syringe
Directions: ____________ Quantity: ___ Refills: ______

Humira citrate free (adalimumab)
☐10mg/0.1ml citrate free Prefilled Syringe Pediatric
☐20mg/0.2ml citrate free Prefilled Syringe Pediatric
☐40mg/0.4ml citrate free ☐Pen ☐Prefilled Syringe
☐80mg/0.8ml citrate free Pens
Directions: ____________ Quantity: ___ Refills: ______

Inflectra (infliximab-dyyb)
☐100mg Vial
Directions: ____________ Quantity: ___ Refills: ______

Kevzara (sarilumab)
☐150mg ☐Syringe ☐Pre-filled Pen
☐200mg ☐Syringe ☐Pre-filled Pen
Directions: ____________ Quantity: ___ Refills: ______

Olumiant
☐2mg Tablets
Directions: ____________ Quantity: ___ Refills: ______

Orencia (abatacept)
☐50mg Prefilled Syringe
☐87.5mg Prefilled Syringe
☐125mg ☐Clickject Pen ☐Prefilled Syringe
☐250mg Vial
Directions: ____________ Quantity: ___ Refills: ______

Otezla (apremilast)
☐Titration Pack
☐30mg Tablets
Directions: ____________ Quantity: ___ Refills: ______

Remicade (infliximab)
☐100mg Vial
Directions: ____________ Quantity: ___ Refills: ______

Renflexis (infliximab-abda)
☐100mg vial
Directions: ____________ Quantity: ___ Refills: ______

Rinvoq (upadacitinib)
☐15mg Tablet
Directions: ____________ Quantity: ___ Refills: ______

Rituxan (rituximab)
☐100mg Vial
☐500mg Vial
Directions: ____________ Quantity: ___ Refills: ______

Simponi (golimumab)
☐50mg ☐Syringe ☐Smartject
Directions: ____________ Quantity: ___ Refills: ______

Simponi Aria (golimumab)
☐50mg Vial
Directions: ____________ Quantity: ___ Refills: ______

Stelara (ustekinumab)
☐45mg Prefilled ☐Syringe ☐Single-dose Vial
☐90mg Prefilled Syringe
Directions: ____________ Quantity: ___ Refills: ______

Taltz (ixekizumab)
☐80mg ☐Prefilled Syringe ☐AutoInjector
Directions: ____________ Quantity: ___ Refills: ______

Tremfya (guselkumab)
☐100mg/ml
☐One-Press Patient-Controlled Injector ☐Prefilled Syringe
Directions: ____________ Quantity: ___ Refills: ______

Xeljanz (tofacitinib)
☐1mg/ml Oral Solution
☐5mg Tablet
Directions: ____________ Quantity: ___ Refills: ______

Xeljanz XR (tofacitinib)
☐11mg Tablet
Directions: ____________ Quantity: ___ Refills: ______

Other
☐ ______________________
Directions: ____________ Quantity: ___ Refills: ______

Other
☐ ______________________
Directions: ____________ Quantity: ___ Refills: ______

Methotrexate – Can only be ordered with other specialty meds.
☐2.5mg Tablet
Directions: ____________ Quantity: ___ Refills: ______

I authorize, by my signature below, the dispensing of appropriate needles and syringes, in a sufficient quantity, required for the administration of injectable products by patient or caregiver. Authorization for supplies runs concurrently with the number of refills or time frame specified for the drug.

PRESCRIBER INFORMATION

Prescriber's name: ______________________ Practice/facility: ______________________

Address: ______________________ City: ____________ State: ______ Zip code: ____________

Office contact: ______________________ Phone: ____________ Fax: ____________

Email: ______________________ Best time to call: ____________ Preferred method of contact: ☐Email ☐Phone ☐Fax

State license #: ____________ DEA #: ____________ NPI #: ____________ Medicaid UPIN #: ____________

In order for a brand name product to be dispensed, the prescriber must handwrite **"Brand Necessary"** or **"Brand Medically Necessary"** or your state specific required language after their signature.
I certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge. Prescriber's signature required on one of the lines below.

______________________ Dispense as written

______________________ Substitution permitted

____________ Date

The prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.

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Drug names are the property of their respective owners.
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