Rheumatoid Arthritis (A-E)

ALLY SCRIPTS ®

Phone: 844-309-7171
Fax: 844-309-7173

1. PATIENT INFORMATION

Patient Name	☐ Male ☐ Female	Allergies ☐ NKDA	
Date of Birth	SSN#	Weight _______kg/ lb Height _____cm/ in	
Address	City	State	Zip
Phone # (Home)	(Work)	Email address(optional)	

2. INSURANCE INFORMATION (PLEASE FAX A COPY OF FRONT AND BACK OF THE INSURANCE CARD(S).

Primary Insurance	RX Ins: BIN________ PCN____________	Policyholder:
Group #	Policy #	Phone #
Secondary Insurance	Policy #	Phone #
Local Pharmacy:	Pharmacy Phone:	

3. DIAGNOSIS/MEDICAL INFORMATION (PLEASE ANSWER ALL QUESTIONS TO PREVENT A DELAY IN PATIENT'S THERAPY.)

☐ M06.9 (Rheumatoid Arthritis)	☐ M08.0 (Juvenile Idiopathic Arthritis)	☐ L40.59 (Psoriatic Arthritis)
☐ L40.54 (Psoriatic Juvenile Arthritis)	☐ L40.90 (Plaque Psoriasis)	Diagnosis Date:_________ TB test: ☐ Yes ☐ No Negative Test Date:____________
Prior Therapy: ☐ Yes ☐ No ______________________________ ______________________________	Reason for Discontinuation of Therapy: ________________ __________________________ Date:____________________	Approximate Start Date: Approximate End

Comorbidities: ____
Concomitant Medications: ____

4. PRESCRIPTION INFORMATION

Humira®, Orencia®, and Otezla® are available on the Rheumatoid Arthritis Form F-R
Simponi ®, Stelara ®, Xeljanz ® and, Xeljanz® XR are available on the Rheumatoid Arthritis Form S-Z

☐ Actemra® (tocilizumab)	☐ Inject 162 mg subcut every week ☐ Inject 162 mg subcut every other week ☐ ________________________	☐ 4 x 162mg/0.9mL ☐ 2 x 162 mg/0.9mL ☐ __________	☐ PFS	____
☐ Cimzia® (certolizumab)	☐ Inject 400mg subcut at weeks 0, 2 and 4	☐ 6 x 200mg/mL	☐ PFS	___
	☐ Inject 200mg subcut every 2 weeks ☐ Inject 400mg subcut every 4 weeks	☐ 2 x 200mg/mL	☐ PFS	___
☐ Enbrel® (etanercept)	☐ Inject 50mg subcut every week ☐ Inject _____ mg (0.8mg/kg x ____kg) subcut every week	☐ 4 x 50 mg/mL ☐ ___ x 25 mg/mL	☐ SureClick® Autoinjector	____

Injection Training Provided by: ☐ Prescriber's Office ☐ Pharmacy ☐ Other: ________________________

Per state-specific law, prescriptions will be dispensed as generic, if applicable, unless notated otherwise:______________________________

5. DELIVERY INSTRUCTIONS

☐ Physician's Office ☐ Patient's Home	☐ Other Address City/State/Zip	Date Medication Needed: If shipping to prescriber:

6. PHYSICIAN CONTACT INFORMATION & AUTHORIZATION

Physician Name	Office Contact	
Phone	Fax	Specialty
Address	City/State/Zip	
License #	DEA #	

Physician's Signature ____ **Date** _____________
(required to process prescription – stamped signatures are not permissible)

I authorize AllyScripts and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time by providing written notice.

Please fax to AllyScripts Specialty Pharmacy at 844-309-7173

Faxed prescription forms will only be accepted from prescribing practitioners.

AllyScripts 11/18

Confidentiality Statement: This message is intended only for the individual or entity to which it is addressed. It may contain information which may be proprietary and confidential. It may also contain privileged, confidential information which is except from disclosure under applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA). If you are not the intended recipient, please note that you are strictly prohibited from disseminating or distributing this information (other than to the indented recipient) or copying the information. If you received this communication in error, please fax to AllyScripts Specialty Pharmacy at 844-309-7173.