Rheumatoid Arthritis (F-R)

ALLY SCRIPTS®

Phone: 844-309-7171
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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)	☐ _____	Diagnosis Date:_____ TB test: ☐ Yes ☐ No Negative Test Date:_____
Prior Therapy: ☐ Yes ☐ No _____ _____	Reason for Discontinuation of Therapy: _____ _____	Approximate Start Date: _____ Approximate End Date:_____

Comorbidities: _____
Concomitant Medications: _____

4. PRESCRIPTION INFORMATION

Actemra®, Cimzia®, and Enbrel® are available on the Rheumatoid Arthritis Form A-E

Medication	Dosage	Quantity		Refills
☐ Humira® (adalimumab) Adults & Pediatrics Age ≥ 2 years	☐ Inject 10mg subcut every other week (10 to <15 kg) ☐ Inject 20 mg subcut every other week (15 to <30 kg) ☐ Inject 40 mg subcut every other week (≥30 kg) ☐ Inject 40 mg subcut once weekly	☐ 2 x 10mg/0.2mL ☐ 2 x 20mg/0.2mL	PFS	_____
		☐ 2 x 40mg/0.8mL ☐ 2 x 40mg/0.8mL	☐ Pens ☐ PFS	
☐ Orencia® (abatacept)	☐ Inject 125mg subcut once weekly	☐ 4 x 125 mg/mL	☐ PFS ☐ ClickJect	_____
☐ Otezla® (apremilast)	☐ Take as directed per package instructions – Starter Pack	☐ 55 tablets	28-day starter pack	_____
	☐ Take 30mg twice daily by mouth	☐ 60 x 30mg tablets		_____
	☐ _____	☐ _____		

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: ☐First Fill ☐Always ☐Never

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.