### RHEUMATOID/PSORIATIC ARTHRITIS REFERRAL FORM (A-E)

**PHONE** 888.370.1724 | **FAX** 877.645.7514

obtain instructions as to proper destruction of the transmitted material.



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PATIENT INFORMATION													
Last Name	First Nar	ne	DOB		Gender	□M □F	Last 4 SS	N		Primary L	.anguage		
Address	<u> </u>			City				Sta	ate		ZIP		
Email		Home Phone			Wo	ork Phone				Cell Pl	hone		
Primary Contact Method (check of	one) 🗆 Cell Ph	none	one 🗆 Work Phor	ne 🗆 T	ext 🗆 E	mail 🗆 Pr	imary Careg	giver 🗆	DO NOT	T CONTACT	Г		
Primary Caregiver/Alt Contact Na	me (If applicab	le)	Alt Cont	act Ema	il					Alt Conta	ct Phone		
PRESCRIBER INFORMATION	ON												
Name of Contact Sending Referra	al		Title			Pref	erred Conta	ct Method	(check	one) 🗆 E	mail 🗆 Pl	hone	□ Fax
Referral Contact Email					Office	Phone			Off	fice Fax			
Practice / Facility Name					Prescri	iber Name /	Specialty						
Address				(	City					State		ZIP	
Prescriber State License #	0	PEA #		1	NPI#				Medi	icaid UPIN	#		
	*	Please include	e a copy of th	e fro	nt and	back of	insurano	ce card	*				
CLINICAL INFORMATION													
Patient New to Therapy ☐ Naïve/								Thoran	y Start D	Dato			
Sample/Starter Provided?			Provided:								ate Obtaine	م	
If Self-injectable drug, is injection						TB Skin Te		Veight (kg		esult Date:	ate Obtaine	u.	
Other/Concomitant Medications (		nation required by c	our pharmacy: 🗆 t	es 🗆 IV		I B SKIII TE	st Resuit.		R	esuit Date.			
		-4\				Other Alle		Links					
	ergies (please lis		. It-as			Other Allei	gies (piease	e list)					
		e Other (please	e list)		¬								
□ L40.59	Arthropathic Ps Other Psoriatic	Arthropathy			□ M08.3 J	Unspecified uvenile rheu			rthritis o	of unspecifi	ied site		
□ M06.9 F	Rheumatoid artl	nritis, unspecified			□ Other _								
PRESCRIPTION INFORMA In order for a brand name pro					Brand Ne	ocessary" o	r "Brand N	1edically	Nacass	arv"			
or your state-specific required											ns.		
MEDICATION	DOSE		DIRECTIO	NS							QT	Υ	REFILLS
☐ Actemra®  IV Administration  Current Weight:kg	□ 80 mg Vial □ 200 mg Via □ 400 mg Via			ance Do		ng/kg IV on 8mg/kg IV					I	-week upply	
IV Administration	☐ 200 mg Via ☐ 400 mg Via ☐ 162 mg/0.9i	I	☐ Mainten ☐ Other: _  <100 kg: ☐ Inject 16 ☐ Inject 16 >100 kg:	62 mg Si	ubQ once		R week	4 weeks	nical res	sults)	I		
IV Administration Current Weight:kg  □ Actemra* SubQ Administration Current Weight:kg  □ Cimzia*	☐ 200 mg Via ☐ 400 mg Via ☐ 162 mg/0.9i ☐ 162 mg/0.9i ☐ 162 mg/0.9i ☐ 162 mg/0.9i	I ml PFS ml ACTPen Autoinjed	Mainten	52 mg Si 52 mg Si 52 mg Si 52 mg Si ose:	ubQ once ubQ once ubQ once	every OTHE	R week (increase ba	4 weeks		sults)	I	upply 2	
IV Administration Current Weight:kg  □ Actemra* SubQ Administration Current Weight:kg	200 mg Via   400 mg Via   400 mg Via   162 mg/0.9i   162 mg/0.9i   162 mg/0.9i   200 mg/ml   200 mg Lyc   200 mg/ml   200 mg/ml   200 mg/ml	I ml PFS ml ACTPen Autoinjee  PFS philized powder via Dose: PFS	Mainten	sance Do 62 mg St 62 mg St 62 mg St ose: O mg (2x nce Dose 00 mg S	ubQ once ubQ once ubQ once x200 mg in	every OTHE every week every week njections) St	R week (increase ba	ased on cli		sults)	sı	2 4	
IV Administration Current Weight:kg  Actemra* SubQ Administration Current Weight:kg  Cirrent Weight:kg  Cimzia*  Note: Lyophilized poweder vials should be prepared and administered by a health care professional.	200 mg Via   400 mg Via   400 mg Via   162 mg/0.9i   162 mg/0.9i   162 mg/0.9i   162 mg/mg/mg/mg/mg/mg/mg/mg/mg/mg/mg/mg/mg/m	I ml PFS ml ACTPen Autoinjed PFS philized powder via Dose: PFS philized powder via	Mainten   Other:	52 mg Si 52 mg Si 52 mg Si 52 mg Si ose: O mg (2x	ubQ once ubQ once ubQ once x200 mg in	every OTHE every week every week	R week (increase ba	ased on cli		sults)	sı	2 4 6	
IV Administration Current Weight:kg  Actemra* SubQ Administration Current Weight:kg  Cirrent Weight:kg  Cimzia*  Note: Lyophilized poweder vials should be prepared and administered by a health care	200 mg Via   400 mg Via   400 mg Via   162 mg/0.9i   162 mg/0.9i   162 mg/0.9i   200 mg/ml   200 mg Lyc   200 mg Lyc   75 mg/0.5 r   150 mg/ml	I ml PFS ml ACTPen Autoinjer  PFS philized powder via Dose: PFS philized powder via nL PFS	Mainten     Other:	62 mg Si 62 mg Si 62 mg Si 62 mg Si 62 mg Si 62 mg (2x nce Dose 00 mg (0x 00 mg (0x 00 mg (0x)	ubQ once ubQ once ubQ once c200 mg in e: subQ ever c2x200 mg	every OTHE every week every week njections) St	R week (increase band) at Week ek SubQ every	4 weeks 4 weeks 4 weeks 3 and 4 3 and 4	4		4- st	2 4 6	
IV Administration Current Weight:kg  Actemra* SubQ Administration Current Weight:kg  Cirrent Weight:kg  Cimzia*  Note: Lyophilized poweder vials should be prepared and administered by a health care professional.	200 mg Via   400 mg Via   400 mg Via   162 mg/0.9i   162 mg/0.9i   162 mg/0.9i   200 mg/ml   200 mg Lyc   200 mg Lyc   75 mg/0.5 r   150 mg/ml	I ml PFS ml ACTPen Autoinjee  PFS philized powder via  Dose: PFS philized powder via  nL PFS PFS PFS	Mainten   Other:	So mg Si So mg Si So mg Si So mg Si So mg (2x Marce Dosse OO mg (2x Marce Dosse So mg Si So mg Si Marce Dosse So mg Si Marce Dosse	ubQ once ubQ once ubQ once ubQ once c200 mg ii e: SubQ ever; (2x200 mg ubQ once v	every OTHE every week njections) Su y OTHER we g injections)	R week (increase ba  ubQ at Weel  ek SubQ every eeks 0, 1, 2, 3 (eeks 0, 1, 2, 5 SubQ once v	4 weeks  4 weeks  4 weeks  3 and 4  3 and 4  weekly at \	4 Weeks 0		4- st	2 4 6 -week upply	
IV Administration Current Weight:kg  Actemra* SubQ Administration Current Weight:kg  Cirrent Weight:kg  Cimzia*  Note: Lyophilized poweder vials should be prepared and administered by a health care professional.	200 mg Via   400 mg Via   400 mg Via   400 mg Via   162 mg/0.9t   162 mg/0.9t   162 mg/ml   200 mg Lyc   200 mg Lyc   200 mg/ml   200 mg Lyc   150 mg/ml   150 mg/ml   50 mg/ml   950 mg	I ml PFS ml ACTPen Autoinjen PFS phillized powder via Dose: PFS phillized powder via nL PFS PFS Sensoready Pen ureclick™ Autoinject FS lini Cartridge (inj supplies included	Mainten	sance Doses To mg Su	ubQ once ubQ once value once valu	every OTHE every week every week njections) Strategy of the granier of the granie	ek SubQ every eeks 0, 1, 2, 3/eeks 0, 1, 2, 5/eubQ once v	4 weeks  4 weeks  4 weeks  3 and 4  3 and 4  4 weekly at \  6 weekly at \  6 weekly at \  7 weekery 4 weekly at \  7 weekly at \  8 weekly at	4 Weeks 0		4- st	2 4 6week upply 5 10week	
IV Administration Current Weight:kg  Actemra* SubQ Administration Current Weight:kg  Cimzia*  Note: Lyophilized poweder vials should be prepared and administered by a health care professional.  Cosentyx*	200 mg Via   400 mg Via   400 mg Via   400 mg Via   162 mg/0.9t   162 mg/0.9t   162 mg/ml   200 mg Lyc   200 mg Lyc   200 mg/ml   200 mg Lyc   150 mg/ml   150 mg/ml   150 mg/ml   25 mg Via   25 mg	I ml PFS ml ACTPen Autoinjee  PFS philized powder via  Dose: PFS peps Sensoready Pen  ureclick™ Autoinjee FS lini Cartridge (inj supplies included ml PFS Inl PFS Inl PFS Inl PFS Inl Sensoready Included	Mainten	Sance Doses: 52 mg Si 52 mg Si 52 mg Si 52 mg Si 53 mg Si 54 mg Si 55 mg Si 56 mg Si 56 mg Si 56 mg Si 57 mg Si 58 mg Si 58 pound 58 pound 58 mg/ki 58 pound 50 mg Si	ubQ once ubQ once v200 mg in soubQ once v2200 mg in soubQ once v2200 mg in soubQ once v22150 mg e: bbQ once v22150 mg ibQ once	every OTHE we ginjections) Si weekly at W weekly at W winjections) si every 4 week every 4 weekly at well at wel	R week (increase ba  abQ at Weel  ek SubQ every eeks 0, 1, 2, 3 (eeks 0, 1, 2, 5 SubQ once v  ss ks SubQ once e	4 weeks 4 weeks 4 weeks 3 and 4 3 and 4 weekly at \ 2 every 4 weekly	Weeks O	), 1, 2, 3 and	4- st 4- st 4- st 4- st 4- st	2 4 6week upply 5 10week upply	
IV Administration Current Weight:kg  □ Actemra* SubQ Administration Current Weight:kg  □ Cimzia*  Note: Lyophilized poweder vials should be prepared and administered by a health care professional.  □ Cosentyx*  □ Enbrel* Adult Dosing □ Enbrel* Pediatric Dosing Children ≥ 2 years old and adolescents	200 mg Via   400 mg Via   400 mg Via   400 mg Via   162 mg/0.9t   162 mg/0.9t   162 mg/ml   200 mg Lyc   200 mg Lyc   200 mg/ml   200 mg Lyc   150 mg/ml   150 mg/ml   150 mg/ml   25 mg Via   25 mg	I ml PFS ml ACTPen Autoinjee  PFS philized powder via  Dose: PFS philized powder via  nL PFS PFS Sensoready Pen  ureclick™ Autoinject FS lini Cartridge (inj supplies included ml PFS ml PFS (inj supplies included FS	Mainten	S2 mg Si S2 mg Si S2 mg Si S3 mg Si S3 mg Si S4 mg Si S5 mg Si S5 mg Si S5 mg Si S6 mg Si S6 mg Si S6 mg Si S7 mg Si S7 mg Si S8 mg Si S8 mg Si S9 mg Si S9 mg Si S9 mg Si	ubQ once ubQ once vector of the control of the cont	every OTHE we ginjections) Si weekly at W weekly at W winjections) si every 4 week every 4 weekly at well at wel	R week (increase ba  abQ at Weel  ek SubQ every  eeks 0, 1, 2, 3  feeks 0, 1, 2, 5  subQ once v  es  sk  sb  bbQ once v  se  yeek 0, 1, 2, 3  feeks 0, 1, 2,	4 weeks used on cli 4 weeks 3 and 4 3 and 4 weekly at \ every 4 weekly at \ ose: 50 mg	Weeks O	), 1, 2, 3 and	4- st 4- st 4- st	2 4 6week upply 5 10week upplyweek upply	

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# RHEUMATOID/PSORIATIC ARTHRITIS REFERRAL FORM (F-O)

**PHONE** 888.370.1724 | **FAX** 877.645.7514



Remove above portion before faxing. Please complete the prescription form in its entirety and fax with secure cover sheet to the number above.

·	_	-				-						
PATIENT INFORMATION												
Last Name	First Name	DOB			Gender	□M □F	Last 4 SSN	ı	Pi	rimary Lan	guage	
Address		'		City				State	e		ZIP	
Email	Home Phone				Wor	rk Phone		'		Cell Pho	ne	
Primary Contact Method (check of	one) 🗆 Cell Phone 🗆 Home	Phone 🗆	Work Phone	- □ Te	ext 🗆 Er	mail 🗆 Pı	rimary Caregi	iver 🗆 D	O NOT CO	ONTACT		
Primary Caregiver/Alt Contact Na	me (If applicable)		Alt Conta	ct Emai	il				А	It Contact	Phone	
PRESCRIBER INFORMATION	ON											
Name of Contact Sending Referra	l	Titl	le	<u></u>		Pref	ferred Contac	t Method (	check one	e) 🗆 Ema	ail 🗆 Phone	□ Fax
Referral Contact Email					Office P	hone			Office	Fax		
Practice / Facility Name					Prescrib	per Name /	Specialty					
Address				(	City					State	ZI	P
Prescriber State License #	DEA #			N	NPI#				Medicai	d UPIN #		
	* Please incl	ude a cor	ny of the	e froi	nt and l	back of	insuranc	e card *				
CLINICAL INFORMATION					re arra s	ouen or	mourane	c cara				
Patient New to Therapy ☐ Naïve/	New Start □ Therapy Restart	☐ Existing	Treatment					Therapy	Start Date	9		
Sample/Starter Provided? ☐ No [	☐ Yes, Provide Qty: □	ate Provided	:	P	Patient Hei	ght (cm/in)	): W	⊥ /eight (kg/ll	bs):	Date	Obtained:	
If Self-injectable drug, is injection	training coordination required	by our pharm	nacy? □ Ye	s 🗆 No	<b>o</b>	TB Skin Te	est Result:		Resu	It Date:		
Other/Concomitant Medications (												
	rgies (please list)					Other Alle	rgies (please	list)				
	rescriber's Office	ease list)					3.22 (12.22.2					
ICD-10 Code	Arthropathic Psoriasis Other Psoriatic Arthropathy Rheumatoid arthritis, unspecifie						l juvenile rheu ımatoid polya		hritis of u	nspecified	site	
PRESCRIPTION INFORMA			hy state									
In order for a brand name pro- or your state-specific required	duct to be dispensed, the p	rescriber m	nust handw	vrite "E								
MEDICATION	DOSE		DIRECTION		and proof	311,521.511.10				37541.57.51	QTY	REFILLS
☐ Humira* Citrate Free	□ 10 mg/0.1 mL PFS				L ma SubC	Avery OTH	JED wook				GI I	INEL IEES
Ename Chaternee	□ 20 mg/0.2 mL PFS □ 40 mg/0.4 mL PFS □ 40 mg/0.4 mL PFS □ 40 mg/0.8 mL Pen □ 80 mg/0.8 mL Pen	ng/0.2 mL PFS ☐ Inject 40/0.4 mL mg SubQ every week mg/0.4 mL PFS ☐ Inject 80/0.8 mL mg SubQ every OTHER week mg/0.4 mL Pen Polyarticular JIA:							4-week supply			
□ Kevzara <sup>*</sup>	□ 200 mg/1.14 ml PFS □ 200mg/1.14ml Autoinjector □ 150 mg/1.14 ml PFS □ 150mg/1.14ml Autoinjector		☐ Inject 150 mg SubQ every 2 weeks ☐ Inject 200 mg SubQ every 2 weeks								4-week supply	
☐ Methotrexate <sup>®</sup>	□ 2.5 mg tablet		Takemg (tablets) by mouth once weekly on the same day each week								4-week supply	
	□ 25 mg/mL (2 mL vial) Inj		Inject	mg S	Q once we	ekly on the	e same day e	ach week			4-week supply	
□ Olumiant	□1 mg tablet □2 mg tablet		☐ Take 2 mg by mouth once daily ☐ Other:								30	
☐ Orencia*  IV Administration  Current Weight:kg	Initial Dose:  Infuse mg IV (over 30 minutes) on Day 1, Day Maintenance Dose:					, Day 15 and	d Day 29		30	0		
	□ 60-100 kg = 750 mg (3 Vial □ >100 kg = 1,000 mg (4 Vial Pediatric: □ <75 kg = 10 mg/kg □ 75-100 kg = 750 mg (3 Vial □ >100 kg = 1,000 mg (4 Vial	s) s)	Infusemg IV (over 30minutes) every 4 weeks							4-week supply		
☐ Orencia <sup>*</sup> SubQ Administration Current Weight:kg	☐ Orencia 125 mg/ml PFS ☐ Orencia 125 mg/ml ClickJec ☐ Orencia 87.5 mg/0.7 ml PFS ☐ Orencia 50 mg/0.4 ml PFS		Adult Dose  Inject 125  Pediatric D  10 to <25  >25 to <5  >50 kg: 1	5 mg Su ose: (>: 5kg: 50 50kg: 8	2 years): mg SubQ 7.5 mg Sub	once weekl					4-week supply	
Prescriber Signature		Date		-	Supervisin	g Physician	n Signature (v	vhere requi	red by sta	ate law)	Date	
DAW (Dispense as Written)	<del></del>	 Date	<del></del>		Brand Nec	essary (mu	st handwrite)	)				

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### RHEUMATOID/PSORIATIC ARTHRITIS REFERRAL FORM (O-R)

**PHONE** 888.370.1724 | **FAX** 877.645.7514



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PATIENT INFORMATION														
Last Name	First Name	DOB			Gender 🗆	м□F	Last 4 SSN		Prin	nary Langua	ige			
Address	·		C	City				State	'	ZIF	,			
Email	Home Ph	none	'		Work F	Phone				Cell Phone				
Primary Contact Method (check of	one) 🗆 Cell Phone 🗆 H	ome Phone	Work Phone	□ Tex	kt 🗆 Emai	I □ Pi	imary Caregiv	er 🗆 DC	NOT CON	NTACT				
Primary Caregiver/Alt Contact Na	me (If applicable)		Alt Contact I	Email					Alt	Contact Pho	one			
PRESCRIBER INFORMATION	ON													
Name of Contact Sending Referra	l	Ti	tle			Pref	erred Contact	Method (cl	neck one)	☐ Email	☐ Phone	□ Fax		
Referral Contact Email					Office Pho				Office Fa					
Practice / Facility Name					Prescriber	Name /	Specialty							
Address				Ci					Si	tate	ZIF	<b>D</b>		
Prescriber State License #	DEA #				PI #				Medicaid					
		nclude a co	ny of the i			ck of	insurance							
CLINICAL INFORMATION					t arra ba	CK OI	msurarrec	curu						
CLINICAL INFORMATION				tes										
Patient New to Therapy ☐ Naïve/			-					Therapy S	tart Date					
Sample/Starter Provided? ☐ No	☐ Yes, Provide Qty:	Date Provide	d:	Pa	tient Height	(cm/in)	: We	ight (kg/lb	s):	Date Ob	te Obtained:			
If Self-injectable drug, is injection	training coordination requ	ired by our phar	macy? 🗆 Yes	□No	TE	Skin Te	st Result:		Result	Date:				
Other/Concomitant Medications (	please list)													
Allergies □ NKDA □ Drug Alle	rgies (please list)				□ Ot	her Alle	rgies (please li	st)						
Ship to Address ☐ Home ☐ Pr	rescriber's Office 🗆 Othe	er (please list)												
□ L40.59	Arthropathic Psoriasis Other Psoriatic Arthropath Rheumatoid arthritis, unspe						juvenile rheun matoid polyari		ritis of uns	specified sit	е			
PRESCRIPTION INFORMA			l hy state la											
In order for a brand name pro	duct to be dispensed, t	he prescriber r	nust handwrit	te "Br										
or your state-specific required		ubstitutions. Ti		t a va	alid prescrip	otion fo	orm for writin	g control.	led medi	cations.				
MEDICATION	DOSE		DIRECTIONS								QTY	REFILLS		
☐ Otezla*	☐ Starter Pack (Titration) (55 tablets)					ay 3: 10 mg AN rting Day 6: Ta								
	☐ Maintance Rx 30 mg (Otezla tablets)		☐ Take one tablet by mouth twice daily ☐ Other:											
	☐ Bridge Rx 30 mg (Otezla tablets)		☐ Take one ta	blet b	y mouth twi	ce daily								
□ Otrexup*	□ 12.5 mg/0.4 ml □ 2	0 mg/0.4 ml 2.5 mg/0.4 ml 5 mg/0.4 ml	□ Inject	mg	SQ once we	ekly on	the same day e	each week			4			
□ Rasuvo*	□ 10 mg/0.2 ml □ 2 □ 12.5 mg/0.25 ml □ 2	0 mg/0.4 ml 2.5 mg/0.45 ml 5 mg/0.5 ml 0 mg/0.6 ml	□ Inject	mg	SQ once we	ekly on	the same day e	each week			4			
□ Remicade* Current Weight:kg	□ 100 mg Vial						ek 0, 2 and 6 (I ek 0, 2 and 6 ( <i>I</i>							
Biosimilars:			☐ Other:											
☐ Avsola ☐ Inflectra			Maintenance I											
☐ Renflexis		Infuse 3 mg/kg ( mg) IV every 8 weeks Infuse 10 mg/kg ( mg) IV every 4 weeks Infuse 10 mg/kg ( mg) IV every 8 weeks AS:												
			Infuse 5 mg/k PsA:	(g (	mg) IV	every 6	weeks							
			Infuse 5 mg/k			every 8	weeks							
			Other:											
Rinvoq	□ 15 mg		☐ Take one 15	mg ta	aplet by mol	ith once	аану							
				_										
Prescriber Signature		Date		S	upervising P	hysician	Signature (wh	ere require	ed by state	e law) l	Date			
DAW (Dispanse as Writton)		Date		В	rand Necess	ary (mu	st handwrite)							

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### RHEUMATOID/PSORIATIC ARTHRITIS REFERRAL FORM (S-T)

**PHONE** 888.370.1724 | **FAX** 877.645.7514



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PATIENT INFORMATION Last Name													
	First Name	DOB			Gender [	M □F	Last 4 SSI	N		Primary	Langua	ige	
Address				City			1	Sta	ate		ZIP	)	
Email	Home Phone				Work	Phone				Cell	Phone		
Primary Contact Method (check one)	☐ Cell Phone ☐ Home I	Phone 🗆	Work Phone	□Те	ext 🗆 Em	ail 🗆 Pı	rimary Careg	iver $\square$	DO NOT	CONTAC	СТ		
Primary Caregiver/Alt Contact Name (If	f applicable)		Alt Contac	ct Emai	I					Alt Con	tact Pho	ne	
PRESCRIBER INFORMATION													
Name of Contact Sending Referral		Tit	le			Pref	ferred Conta	ct Method	(check	one) $\square$	Email	☐ Phone	□ Fax
Referral Contact Email					Office Ph	one			Offi	ice Fax			
Practice / Facility Name					Prescribe	r Name /	Specialty						
Address				C	ity					State		ZII	<b>)</b>
Prescriber State License #	DEA #			N	IPI#				Medi	caid UPIN	N #		
	* Please inclu	ide a coi	pv of the	e fror	nt and b	ack of	insurano	e card	*				
CLINICAL INFORMATION - Ple													
Patient New to Therapy ☐ Naïve/New S				otes				Thoran	y Start D	ato			
Sample/Starter Provided? ☐ No ☐ Yes,		ite Provided		П	atient Heig	at (cm/in)	. \	Veight (kg	-	Date Obtained:			
	•							veight (kg				taineu.	
If Self-injectable drug, is injection training		by our pnarn	nacy? U Yes	S LINC	)	B SKIN TE	st Result:		Re	esult Date	9:		
Other/Concomitant Medications (please													
Allergies NKDA Drug Allergies						ther Alle	rgies (please	list)					
<u> </u>	ber's Office	ase list)											
	opathic Psoriasis Psoriatic Arthropathy						juvenile rhe matoid poly		rthritis o	of unspec	ified site	Э	
□ M06.9 Rheum	natoid arthritis, unspecified				Other								
PRESCRIPTION INFORMATION In order for a brand name product					Prand Noc	occarv" o	r "Prand M	lodically	Nocoss	oru"			
or your state-specific required lang											ons.		
MEDICATION DOS	SE .		DIRECTION	IS								QTY	REFILLS
	0 mg/0.5 ml SmartJect* Au 0 mg/0.5 ml PFS	toinjector	☐ Inject 50	ma Sub	Q once a m	onth						1 month	
			ing out								supply		
☐ Simponi Aria ☐ 50 Current Weight:kg	0 mg/4 ml Vial		Adult Dosir Infuse 2 mg	ng, Indu	ıction Dose:		Veek O and V	Veek 4				supply	
	O mg/4 ml Vial	-		ng, Indu g/kg ( ng, Mair	iction Dose:	g) IV at W		Veek 4				supply	
	0 mg/4 ml Vial		Adult Dosir Infuse 2 mg	ng, Indu g/kg ( ng, Mair g/kg ( osing ((	nction Dose: m ntenance Do m Children >2	g) IV at V se: g) IV ever		s), Inducti	on Dose:	:		supply	
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	0 mg/4 ml Vial	-	Adult Dosir Infuse 2 mg Pediatric Do Infuse 2 mg Pediatric Do	ng, Indu g/kg ( ng, Mair g/kg ( osing (( g/kg ( osing ((	nction Dose: mntenance Domintenance Domintenance Mr. Children >2 mr. Children >2	g) IV at V se: g) IV ever years and g) IV at V years and	ry 8 weeks I Adolescent Veek 0 and V	s), Inducti Veek 4				supply	
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## RHEUMATOID/PSORIATIC ARTHRITIS REFERRAL FORM (U-Z)

**PHONE** 888.370.1724 | **FAX** 877.645.7514



Remove above portion before faxing. Please complete the prescription form in its entirety and fax with secure cover sheet to the number above.

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CLINICAL INFORMATION -	- Please inclu	de applicable	clinical chart r	otes									
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