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

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		Primary Lar	nguage	
Address		City				State		ZIP	
Email	Home Phone	I	Work Pho	ne			Cell Pho	one	
Primary Contact Method (check o	one) 🗆 Cell Phone 🗆 Home Phone 🛛	Work Phone 🛛 Te	xt 🗆 Email	🗆 Pri	mary Caregiver		CONTACT		
Primary Caregiver/Alt Contact Na	me (If applicable)	Alt Contact Email					Alt Contact	Phone	
PRESCRIBER INFORMATIO	NC								
Name of Contact Sending Referra	т	ītle		Prefe	erred Contact Met	hod (check	one) 🗆 Em	ail 🗆 Phone	🗆 Fax
Referral Contact Email			Office Phone			Off	ice Fax		
Practice / Facility Name			Prescriber Na	me / s	Specialty				
Address		с	ity				State	ZIP	
Prescriber State License #	DEA #	N	PI #			Med	icaid UPIN #	· ·	
	* Please include a co	opy of the fron	t and back	k of I	insurance ca	ard *			
CLINICAL INFORMATION	- Please include applicable clini	ical chart notes							
Patient New to Therapy 🗆 Naïve/	New Start 🛛 Therapy Restart 🖓 Existir	ng Treatment			The	erapy Start [	Date		
Sample/Starter Provided? 🗆 No 🛛	☐ Yes, Provide Qty: Date Provide	ed: Pa	atient Height (c	m/in):	Weight	(kg/lbs):	Date	Obtained:	
If Self-injectable drug, is injection	training coordination required by our pha	rmacy? 🗆 Yes 🗆 No	TB SI	kin Tes	t Result:	R	esult Date:		
Other/Concomitant Medications (	please list)								
Allergies 🗆 NKDA 🗆 Drug Alle	rgies (please list)		🗆 Other	r Allerg	gies (please list)				
Ship to Address	rescriber's Office 🛛 Other (please list)								
	Arthropathic Psoriasis				juvenile rheumato		of unspecified	d site	
	Other Psoriatic Arthropathy Rheumatoid arthritis, unspecified		M08.3 Juvenile Other	rheun	natoid polyarthrit	is			
In order for a brand name pro	TION - Please Escribe if required duct to be dispensed, the prescriber I language to prohibit substitutions. 7	must handwrite "B							
MEDICATION	DOSE	DIRECTIONS						QTY	REFILLS
Actemra*     IV Administration     Current Weight:kg	□ 80 mg Vial □ 200 mg Vial □ 400 mg Vial	□ Induction dose: I □ Maintenance Dos □ Other:				(S		4-week supply	
Actemra*     SubQ Administration     Current Weight:kg	□ 162 mg/0.9ml PFS □ 162 mg/0.9ml ACTPen Autoinjector	<100 kg:	bQ once every	week (		n clinical res	ults)	2 4	
□ Cimzia* Note: Lyophilized poweder	Initial Dose: □ 200 mg/ml PFS □ 200 mg Lyophilized powder vial	□ Initial Dose: Inject 400 mg (2x2	200 mg injectio	ns) Su	bQ at Weeks 0, 2	and 4		6	
vials should be prepared and administered by a health care professional.	Maintenance Dose: 200 mg/ml PFS  200 mg Lyophilized powder vial	Maintenance Dose: Inject 200 mg Su Inject 400 mg (2	bQ every OTH			:ks		4-week supply	
Cosentyx*	□ 75 mg/0.5 mL PFS □ 150 mg/ml PFS □ 150 mg/ml Sensoready Pen	Loading Dose: Inject 75 mg Sub Inject 150 mg Su Inject 300 mg (2	bQ once weekly	at W	eeks 0, 1, 2, 3 and	4	, 1, 2, 3 and 4	5 10	
		Maintenance Dose:         Inject 75 mg SubQ once every 4 weeks         Inject 150 mg SubQ once every 4 weeks         Inject 150 mg (2x150 mg injections) SubQ once every 4 weeks							
Enbrel*     Adult Dosing	<ul> <li>□ 50 mg/ml Sureclick<sup>™</sup> Autoinjector</li> <li>□ 50 mg/ml PFS</li> <li>□ 50 mg/ml Mini Cartridge</li> <li>□ 25 mg Vial (inj supplies included)</li> <li>□ 25 mg /0.5 ml PFS</li> </ul>	□ Inject 25 mg Sub						4-week supply	
□ Enbrel* Pediatric Dosing Children ≥ 2 years old and adolescents Current Weight:kg	□ 25 mg/0.5 ml PFS □ 25 mg Vial (inj supplies included) □ 50 mg/ml PFS □ 50 mg /ml Sureclick™ Autoinjector	<63 kg (138 pound: Inject 0.8 mg/kg >63 kg (138 pound: Inject 50 mg Sub Other:	/dose SubQ on s):		eek (max dose: 50	0 mg/dose)		4-week supply	

Prescriber Signature	Date	Supervising Physician Signature (where required by state law)
DAW (Dispense as Written)	Date	Brand Necessary (must handwrite)

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Date

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

PHONE 888.370.1724 | FAX 877.645.7514



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PATIENT INFORMATION								
Last Name	First Name DOB	В	Gender 🗆 M	□ F Last 4 SSN		Primary Langua	ige	
Address	l l	City			State	ZIF	)	
Email	Home Phone		Work Pho	one		Cell Phone		
Primary Contact Method (check	one) 🗆 Cell Phone 🗆 Home Phone	□ Work Phone □ Te	ext 🗆 Email	Primary Caregive	r 🗆 DO NOT	CONTACT		
Primary Caregiver/Alt Contact Na	me (If applicable)	Alt Contact Emai	1			Alt Contact Pho	one	
PRESCRIBER INFORMATI	ON							
Name of Contact Sending Referra	I	Title		Preferred Contact N	1ethod (check	one) 🗆 Email	Phone	🗆 Fax
Referral Contact Email			Office Phone	1	Off	ice Fax		
Practice / Facility Name			Prescriber Na	me / Specialty				
Address		c	lity			State	ZIP	
Prescriber State License #	DEA #	N	IPI #		Medi	caid UPIN #		
	* Please include a c	copy of the from	nt and bacl	k of insurance	card *			
CLINICAL INFORMATION	- Please include applicable clin	nical chart notes						
	New Start 🛛 Therapy Restart 🗆 Exist				Therapy Start D	ate		
Sample/Starter Provided?		-	atient Height (c		ght (kg/lbs):	Date Ob	tained:	
	training coordination required by our ph			kin Test Result:		esult Date:		
Other/Concomitant Medications (						-		
Allergies NKDA Drug Alle	· · · · · · · · · · · · · · · · · · ·		□ Othe	r Allergies (please lis	t)			
Ship to Address	rescriber's Office 🛛 Other (please list)				-			
	Arthropathic Psoriasis		M08.00 Unspe	cified juvenile rheum	atoid arthritis c	of unspecified sit	9	
□ L40.59	Other Psoriatic Arthropathy Rheumatoid arthritis, unspecified			rheumatoid polyarth			-	
	TION - Please Escribe if require							
	duct to be dispensed, the prescriber I language to prohibit substitutions.							
MEDICATION	DOSE	DIRECTIONS			, controllorio a n	in our out of their	QTY	REFILLS
Humira* Citrate Free	□ 10 mg/0.1 mL PFS	□ Inject 40/0.4 mL	ma SubQ ever	v OTHER week				
	□ 20 mg/0.2 mL PFS □ 40 mg/0.4 mL PFS	□ Inject 40/0.4 mL □ Inject 80/0.8 mL	mg SubQ ever	y week			4-week	
	□ 40 mg/0.4 mL Pen □ 80 mg/0.8 mL Pen			Inject 10 mg/0.1 mL			supply	
				): Inject 20 mg/0.2 m 0 mg/0.4 mL SubQ e				
🗆 Kevzara*	□ 200 mg/1.14 ml PFS	🗆 Inject 150 mg Su	bQ every 2 wee	ks				
	200mg/1.14ml Autoinjector     150 mg/1.14 ml PFS	🗆 Inject 200 mg Si	ubQ every 2 we	eks			4-week supply	
	□ 150mg/1.14ml Autoinjector							
Methotrexate <sup>*</sup>	□ 2.5 mg tablet	Takemg (	tablets) b	y mouth once weekly	on the same d	ay each week	4-week supply	
	🗆 25 mg/mL (2 mL vial) Inj	Injectmg S	Q once weekly	on the same day eacl	n week		4-week supply	
🗆 Olumiant	□ 1 mg tablet □ 2 mg tablet	□ Take 2 mg by mo □ Other:					30	
Orencia <sup>*</sup>	Orencia 250 mg Vial	Initial Dose:				20	30	0
IV Administration Current Weight:kg	Adult: □ <60 kg = 500 mg (2 Vials)			minutes) on Day 1, D	ay 15 and Day A	29		
	□ 60-100 kg = 750 mg (3 Vials) □ >100 kg = 1,000 mg (4 Vials)	Maintenance Dose Infusem		nutes) every 4 weeks				
	Pediatric:						4-week supply	
	□ 75-100 kg = 750 mg (3 Vials) □ >100 kg = 1,000 mg (4 Vials)							
□ Orencia <sup>®</sup>	Orencia 125 mg/ml PFS	Adult Dose:						
SubQ Administration	□ Orencia 125 mg/ml ClickJect™	□ Inject 125 mg Su	bQ once weekly	/				
Current Weight:kg	□ Orencia 87.5 mg/0.7 ml PFS □ Orencia 50 mg/0.4 ml PFS	Pediatric Dose: (>2		wookly			4-week supply	
		□ 10 to <25kg: 50 □ >25 to <50kg: 87	7.5 mg SubQ on	ce weekly				
		□ >50 kg: 125 mg 9	SubQ once wee	kly				

Prescriber Signature Date

Supervising Physician Signature (where required by state law)

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DAW (Dispense as Written)

Date

Brand Necessary (must handwrite)

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Date

# 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	DC	B		Gender	M	DF	Last 4 SSN		Pr	rimary Langua	ige	
Address				City					State		ZIF	)	
Email	Но	me Phone			w	ork Pho	ne				Cell Phone		
Primary Contact Method (check o	one) 🗆 Cell Phone	□ Home Phone	U Work Phone	e 🗆 Te	ext 🗆	Email	🗆 Prir	nary Caregiver		от со	ONTACT		
Primary Caregiver/Alt Contact Na	me (If applicable)		Alt Conta	ct Emai	I					A	It Contact Pho	one	
PRESCRIBER INFORMATI	ON												
Name of Contact Sending Referra	1		Title				Prefe	rred Contact Me	thod (che	ck one	e) 🗆 Email	🗆 Phone	🗆 Fax
Referral Contact Email		I			Office	Phone				Office	Fax		
Practice / Facility Name					Presc	riber Na	me / S	pecialty					
Address				С	City						State	ZI	P
Prescriber State License #	DEA #			N	IPI #				м	ledicai	d UPIN #		
	* Plea	se include a	copy of th	e fror	nt and	back	of i	nsurance c	ard *				
CLINICAL INFORMATION	- Please include	applicable cli	nical chart r	notes									
Patient New to Therapy 🗆 Naïve/	New Start 🛛 Thera	py Restart 🛛 Exis	ting Treatment					Th	erapy Sta	rt Date	9		
Sample/Starter Provided?	□ Yes, Provide Qty:	Date Provi	ded:	P	atient H	eight (cr	m/in):	Weigh	t (kg/lbs)	:	Date Ob	tained:	
If Self-injectable drug, is injection	training coordination	n required by our pl	harmacy? 🗆 Ye	s 🗆 No	>	TB Sk	in Test	Result:		Resu	lt Date:		
Other/Concomitant Medications (	please list)												
Allergies 🗆 NKDA 🛛 Drug Alle	rgies (please list)					🗆 Other	Allerg	ies (please list)					
Ship to Address	rescriber's Office	Other (please list)											
□ L40.59	Arthropathic Psorias Other Psoriatic Arthr Rheumatoid arthritis,	opathy				Juvenile		uvenile rheumat atoid polyarthri		is of u	nspecified sit	e	
PRESCRIPTION INFORMA	TION - Please E	scribe if requir	ed by state	law									
In order for a brand name pro or your state-specific required													
MEDICATION	DOSE		DIRECTION									QTY	REFILLS
□ Otezla*	□ Starter Pack (Titr (55 tablets)	ation)	🗆 Day 1: 10	mg AM 20 mg				y 3: 10 mg AM ai ing Day 6: Take					
	□ Maintance Rx 30 mg (Otezla table	ets)	□ Take one □ Other:		by mout	h twice o	daily						
	□ Bridge Rx 30 mg (Otezla table	ets)	□ Take one	tablet l	by mout	h twice o	daily						
□ Otrexup*	□ 10 mg/0.4 ml □ 12.5 mg/0.4 ml □ 15 mg/0.4 ml □ 17.5 mg/0.4 ml	□ 20 mg/0.4 ml □ 22.5 mg/0.4 m □ 25 mg/0.4 ml		mg	g SQ onc	e weekly	y on th	e same day eac	h week			4	
🗆 Rasuvo*	□ 7.5 mg/0.15 ml □ 10 mg/0.2 ml □ 12.5 mg/0.25 ml □ 15 mg/0.3 ml □ 17.5 mg/0.35 ml	□ 20 mg/0.4 ml □ 22.5 mg/0.45 r □ 25 mg/0.5 ml □ 30 mg/0.6 ml	□ Inject nl	□ Injectmg SQ once weekly on the same day each week						4			
Current Weight:kg	🗆 100 mg Vial		Infuse 3 m Infuse 5 m	Initial Dose:           Infuse 3 mg/kg ( mg) IV at Week 0, 2 and 6 (RA)           Infuse 5 mg/kg ( mg) IV at Week 0, 2 and 6 (AS, PsA)           □ Other:									
			Maintenand Infuse 3 m Infuse 10 m Infuse 10 m AS: Infuse 5 m PsA:	g/kg ( ng/kg (_ ng/kg (_ g/kg (	m m m	g) IV ev g) IV ev g) IV eve	ery 4 v ery 8 v ery 6 w	veeks veeks veeks					
			Infuse 5 mg		m	g) IV eve	ery 8 w	veeks					
	🗆 15 mg		Take end	15 mg 1	tablet by	mouth	once c	laily					

Prescriber Signature	Date	Supervising Physician Signature (where required by state law)	Date
DAW (Dispense as Written)	Date	Brand Necessary (must handwrite)	

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No.

# 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	e DC	DB		Gender	ΠM	□F	Last 4 SSN			Primar	ry Langua	ige	
Address		I		City					St	ate	1	ZIF	,	
Email		Home Phone			Wo	ork Pho	ne				Cel	ll Phone		
Primary Contact Method (check o	one) 🗆 Cell Pho	ne 🗆 Home Phone	Work Phone	🗆 Te	ext 🗆 E	Email	🗆 Pri	mary Caregive	r 🗆	DO NOT		ACT		
Primary Caregiver/Alt Contact Na	me (If applicable)	)	Alt Contac	t Email	I						Alt Co	ntact Pho	one	
PRESCRIBER INFORMATI	ON													
Name of Contact Sending Referra	I		Title				Prefe	rred Contact I	dethoo	l (check	one) [	🗆 Email	🗆 Phone	🗆 Fax
Referral Contact Email					Office	Phone				Off	ice Fax			
Practice / Facility Name					Prescr	iber Na	me / S	pecialty						
Address				с	City						State	e	ZIF	þ
Prescriber State License #	DE	A #		N	IPI #					Medi	icaid UP	'IN #		
	* <b>P</b> I	lease include a	copy of the	e fron	nt and	back	c of i	insurance	caro	*				
CLINICAL INFORMATION	- Please inclu	ıde applicable cli	nical chart n	otes										
Patient New to Therapy 🗆 Naïve/	New Start 🛛 Th	erapy Restart 🛛 Exis	ting Treatment						Therap	y Start D	Date			
Sample/Starter Provided? 🗆 No 🛛	□ Yes, Provide Qt	y: Date Provi	ided:	Pa	atient He	eight (ci	m/in):	Weig	ght (kg	J/lbs):		Date Ob	tained:	
If Self-injectable drug, is injection	training coordina	ation required by our p	harmacy? 🗆 Yes	s 🗆 No	)	TB Sk	kin Tes	t Result:		Re	esult Dat	te:		
Other/Concomitant Medications (	please list)					1								
Allergies 🗆 NKDA 🗆 Drug Alle	rgies (please list)	1			C	] Other	Allerg	gies (please lis	t)					
Ship to Address	rescriber's Office	□ Other (please list)	)											
	Arthropathic Pso							uvenile rheum		arthritis c	of unspe	cified sit	е	
	Other Psoriatic A Rheumatoid arthri				008.3 J Other		rheun	natoid polyarth	nritis					
PRESCRIPTION INFORMA				law										
In order for a brand name pro	auct to ne aisn			11 (15)				"D 114						
or your state-specific required												tions.		
or your state-specific required				not a va								tions.	QTY	REFILLS
	l language to pi	rohibit substitutions SmartJect® Autoinject	DIRECTION	not a va Is	alid pres	scriptio	on for					tions.	QTY 1 month supply	
MEDICATION	DOSE	rohibit substitutions SmartJect* Autoinject PFS	DIRECTION	not a va IS mg Sub ng, Indu	alid pres	scriptio a month ose:	on for		g cont			tions.	1 month	
MEDICATION   Simponi  Simponi Aria	language to pr DOSE □ 50 mg/0.5 ml □ 50 mg/0.5 ml	rohibit substitutions SmartJect* Autoinject PFS	DIRECTION	no <i>t a va</i> IS mg Sub ng, Indu I/kg ( ng, Main	alid pres	scription a month ose: _ mg) IV Dose:	on for	rm for writing	g cont			tions.	1 month	
MEDICATION   Simponi  Simponi Aria	language to pr DOSE □ 50 mg/0.5 ml □ 50 mg/0.5 ml	rohibit substitutions SmartJect* Autoinject PFS	This form is n     DIRECTION     Or □ Inject 500     Adult Dosin     Infuse 2 mg     Adult Dosin     Infuse 2 mg     Pediatric Do	not a va IS mg Sub ng, Indua //kg ( ng, Main //kg ( osing (C	oQ once a nction Do- ntenance	scription a month ose: _mg) IV Dose: _mg) IV >2 year	at We v at We v every s and J	rm for writing	ek 4	rolled n	nedicat	tions.	1 month	
MEDICATION   Simponi  Simponi Aria	language to pr DOSE □ 50 mg/0.5 ml □ 50 mg/0.5 ml	rohibit substitutions SmartJect* Autoinject PFS	This form is n     DIRECTION     DIRECTION     Or □ Inject 500     Adult Dosin     Infuse 2 mg     Adult Dosin     Infuse 2 mg     Pediatric Du     Infuse 2 mg     Pediatric Du     Infuse 2 mg     Pediatric Du	not a va IS mg Sub ng, Indu ng, Main n/kg ( osing (C 1/kg ( osing (C	alid pres	scription a month ose: _ mg) IV Dose: _ mg) IV >2 year _ mg) IV >2 year	/ at We / every s and . / at We s and .	eek 0 and Wee 7 8 weeks Adolescents), eek 0 and Wee Adolescents),	ek 4 Inductiek 4	ion Dose	nedicat	tions.	1 month	
MEDICATION   Simponi  Simponi Aria	language to pr DOSE □ 50 mg/0.5 ml □ 50 mg/0.5 ml	rohibit substitutions SmartJect* Autoinject PFS	This form is n     DIRECTION     DIRECTION     Or □ Inject 500     Adult Dosin     Infuse 2 mg     Pediatric Do     Infuse 2 mg     Pediatric Do     Infuse 2 mg     Pediatric Do     Infuse 2 mg	not a va IS mg Sub ng, Indua ng, Main n/kg ( osing (C 1/kg ( osing (C	alid pres	scription a month ose: _ mg) IV Dose: _ mg) IV >2 year _ mg) IV >2 year	/ at We / every s and . / at We s and .	eek 0 and Wee 7 8 weeks Adolescents), eek 0 and Wee Adolescents),	ek 4 Inductiek 4	ion Dose	nedicat	tions.	1 month	
MEDICATION   Simponi  Simponi Aria	language to pr DOSE □ 50 mg/0.5 ml □ 50 mg/0.5 ml	rohibit substitutions SmartJect* Autoinject PFS ial	This form is n     DIRECTION     DIRECTION     Or □ Inject 500     Adult Dosin     Infuse 2 mg     Adult Dosin     Infuse 2 mg     Pediatric Du     Infuse 2 mg     Pediatric Du     Infuse 2 mg     Pediatric Du	not a va mg Sub ng, Indu /kg ( ng, Main /kg ( osing (C /kg ( osing (C /kg ( ng: osse: mg Sub	alid pres	scription a month sse: _mg) IV Dose: _mg) IV >2 year _mg) IV >2 year _mg) IV >2 year _mg) IV	/ at We / every s and . / at We s and .	eek 0 and Wee 7 8 weeks Adolescents), eek 0 and Wee Adolescents),	ek 4 Inductiek 4	ion Dose	nedicat	tions.	1 month	
MEDICATION          Simponi*         Simponi Aria*         Current Weight:        kg	language to pr DOSE □ 50 mg/0.5 ml □ 50 mg/4 ml V □ 50 mg/4 ml V	rohibit substitutions SmartJect* Autoinject PFS ial	This form is n     DIRECTION     DIRECTION     Or     Inject 500     Adult Dosin     Infuse 2 mg     Adult Dosin     Infuse 2 mg     Pediatric Dr     Infuse 2 mg     Other Dosin     Infuse 2 mg     Other Dosin     Inject 45     Inject 45	mg Sub mg Sub mg Sub /kg (	alid pres	scription a month see: _ mg) IV >2 year _ mg) IV >2 year _ mg) IV >2 year _ mg) IV y 1 yy 1 yy 1 yy 29 an	on for a f at We f every s and a f every s and a f every d every	eek 0 and Wee 7 8 weeks Adolescents), eek 0 and Wee Adolescents),	g cont ok 4 Inducti ik 4 Mainte	ion Dose	nedicat	tions.	1 month	
MEDICATION   Simponi Aria <sup>*</sup> Current Weight:kg   Stelara Current Weight:kg  (recommended dose for coexistent PsA & PsO in	language to pr DOSE □ 50 mg/0.5 ml □ 50 mg/4 ml V □ 50 mg/4 ml V	rohibit substitutions SmartJect* Autoinject PFS ial PFS FS	This form is n     DIRECTION     DIRECTION     Or     Inject 500     Adult Dosin     Infuse 2 mg     Adult Dosin     Infuse 2 mg     Pediatric Dr     Infuse 2 mg     Other Dosin     Infuse 2 mg     Other Dosin     Inject 45     Inject 45	mg Sub mg Sub mg Sub /kg (	alid pres oQ once a action Do ntenance Children 3 Children 3 Child	scription a month a month see: _ mg) IV >2 year _ mg) IV >2 year _ mg) IV >2 year _ mg) IV y 1 yy 1 yy 1 yy 1 yy 29 an yy 29 an yy 29 an	on for ' at We ' at We	m for writing eek 0 and Wee 7 8 weeks Adolescents), 9 8 weeks Adolescents), 7 8 weeks y 12 weeks the y 12 weeks the	g cont ok 4 Inducti ik 4 Mainte	ion Dose	nedicat	tions.	1 month	
MEDICATION  Distribution  Simponi Aria* Current Weight:kg  Stelara Current Weight:kg (recommended dose for coexistent PsA & PsO in patients>100kg = 90mg)	( language to pri DOSE 50 mg/0.5 ml 50 mg/0.5 ml 50 mg/4 ml V 45 mg/0.5 ml 90 mg/1 ml Pl 80 mg/ml PF5	rohibit substitutions SmartJect* Autoinject PFS ial PFS FS	This form is r     DIRECTION     DIRECTION     OIRECTION     Adult Dosin     Infuse 2 mg     Adult Dosin     Infuse 2 mg     Pediatric Dr     Infuse 2 mg     Pediatric Dr     Infuse 2 mg     Other Dosin     Infuse 2 mg     Other Dosin     Inject 45     Inject 90     Maintenanc     Inject 45     Inject 90     Induction D     Inject 160     Inject 80	mg Sub mg Sub mg Sub mg Sub /kg ( ng, Main /kg ( ossing (C /kg ( ng: ng Sub mg Sub mg Sub mg Sub mg Sub sose (Ps Dong (2x8 mg Sub cose (Ps Dong (2x8 mg Sub	alid pres oQ once a inction Do intenance Children : Children : Children : Children : Children : Children : Children : Sofiation da bQ on da bQ on da bQ on da bQ on da soriatic A k(80mg) Su Soriasis o BOmg) Su Q at week	scription a month bse: _ mg) IV Dose: _ mg) IV >2 year _ mg) IV >2 year _ mg) IV >2 year _ mg) IV >2 year _ mg) IV y 1 ay 1 ay 29 an ay 20	d every d every cate at We d every d every cate at d ever cate at atic Ar	m for writing eek 0 and Wee 7 8 weeks Adolescents), 9 8 weeks Adolescents), 7 8 weeks y 12 weeks the y 12 weeks the	g cont ek 4 Inducti k 4 Mainte ereafte ereafte existing Su g r throu	rolled n ion Dose nance Do r r g Psorias bQ at we gbQ at we	is): ek 2		1 month	
MEDICATION  Distribution  Simponi Aria* Current Weight:kg  Stelara Current Weight:kg (recommended dose for coexistent PsA & PsO in patients>100kg = 90mg)	( language to pri DOSE 50 mg/0.5 ml 50 mg/0.5 ml 50 mg/4 ml V 45 mg/0.5 ml 90 mg/1 ml Pl 80 mg/ml PF5	rohibit substitutions SmartJect* Autoinject PFS ial PFS FS	This form is r     DIRECTION     DIRECTION     Or □ Inject 500     Adult Dosin     Infuse 2 mg     Pediatric Du     Infuse 2 mg     Pediatric Du     Infuse 2 mg     Other Dosin     Infuse 2 mg     Other Dosin     Inject 45     □ Inject 45     □ Inject 45     □ Inject 45     □ Inject 160     □ Inject 160     □ Inject 800     □ Inject 800	mg Sub mg Sub mg Sub /kg (	alid pres oQ once a inction Do intenance Children : Children : Chi	scription a month bse: _ mg) IV Dose: _ mg) IV >2 year _ mg) IV _ mg) IV IV IV IV IV IV IV IV IV IV IV IV IV I	d every d every c every d every c every c every c every c every d ever c every c every c every c every c every c every c every c every	m for writing eek 0 and Wee 7 8 weeks Adolescents), 9 ek 0 and Wee Adolescents), 7 8 weeks 9 12 weeks the y 12 weeks the y 12 weeks the followed by 80 weeks thereafte	g cont sk 4 Inducti sk 4 Mainte ereafte ereafte existing Su er throu	r nance Do r r g Psorias bQ at we gh week	is): is):		1 month	

Prescriber Signature	Date	Supervising Physician Signature (where required by state law)	Date
DAW (Dispense as Written)	Date	Brand Necessary (must handwrite)	

Note: The information contained in this document will become a legal prescription. Prescriber is to comply with his/her state specific Pharmacy and Medical Board guidelines such as e-prescribing, state specific prescription form, fax language, number of prescriptions allowed on a single prescription form, etc. If more than one page is required, make additional copies. Non-compliance with state specific requirements could result in outreach to the prescriber.

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No.

# 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.

PATIENT INFORMATION								_						_	
Last Name	First Nan	ne	DOB			Gen	der 🗆 M	ΠF	Last 4 SSN			Primary La	nguage		
Address					City					Sta	te		ZIP		
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Primary Caregiver/Alt Contact Name	(If applicabl	e)		Alt Contac	ct Emai	il						Alt Contac	t Phone		
PRESCRIBER INFORMATION	J														
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CLINICAL INFORMATION - I	Please inc	lude applicable	clini	cal chart n	otes										
Patient New to Therapy 🗆 Naïve/Ne	w Start 🛛 🗆	Therapy Restart 🛛	Existin	ng Treatment						Therapy	Start Da	ate			
Sample/Starter Provided? $\Box$ No $\Box$ Y	es, Provide C	Qty: Date F	Provide	ed:	F	Patient	t Height (cı	m/in):	Wei	ght (kg/	lbs):	Dat	e Obtained	1:	
If Self-injectable drug, is injection tra	ining coordi	nation required by o	ur phai	rmacy? 🗆 Yes	s ⊡No	o	TB Sk	kin Tes	t Result:		Re	sult Date:			
Other/Concomitant Medications (ple	ase list)														
Allergies 🗆 NKDA 🛛 Drug Allergi	es (please lis	st)					🗆 Other	r Allerg	gies (please lis	t)					
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PRESCRIPTION INFORMATION - Please Escribe if required by state law 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 to prohibit substitutions. This form is not a valid prescription form for writing controlled medications.															
MEDICATION D	OSE			DIRECTION									QT		REFILLS
□ Xatmep <sup>•</sup> □	2.5 mg/ml o	ral solution		🗆 Take	mg	one ti	me weekly	/					1 m	onth	
□ Xeljanz <sup>•</sup> □	5 mg tablet			□ Take one	tablet	by mo	outh once c	daily						60	
□ Xeljanz XR <sup>*</sup>	11 mg XR tal	olet		□ Take one	tablet	by mo	outh once o	daily						30	

Prescriber Signature	Date	Supervising Physician Signature (where required by state law) Date						
 DAW (Dispense as Written)	Date	Brand Necessary (must handwrite)						

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