Ph: 877.227.3405 • Fax: 877.542.2731 • E-Prescribe NPI # 1659380772 or NCPDP # 3306986

CareMed SPECIALTY PHARMACY

Rheumatology Prescription Form

PATIENT INFORMATION You may also fax demographics/face sheet

Patient Name:_____DOB: _____
SSN: _____
Address: _____
City, State, Zip: _____
Home Phone: _____Cell Phone: _____
Known Allergies: _____
Height: _____ Weight: _____lbs. ☐ M ☐ F
Emergency Contact: _____
Emergency Contact Phone: _____

INSURANCE INFO. Please fax copy of ALL insurance cards *front & back

Primary Insurance: _____
City, State: _____
ID Number: _____
Group Number: _____ Rx Bin: _____
Secondary Insurance: _____
City, State: _____
ID Number: _____
Group Number: _____ Rx Bin: _____

PRESCRIBER INFORMATION

Prescriber Name: _____ License: _____ DEA: _____
Address: _____ City, State, Zip: _____
Office Contact: _____ Phone: _____ Fax: _____

DIAGNOSIS INFORMATION Please fax recent labs, clinical notes, etc. to help expedite the prior authorization process

☐ Rheumatoid Arthritis ☐ Psoriatic Arthritis ☐ Other: _____
ICD-10: _____ Prior Failed Therapies: _____
Reason For Discontinuation:_____

MEDICATIONS: You may tape Prescriptions here prior to faxing

MEDICATION	DOSE/STRENGTH	SIG	QTY	REFILLS
☐**Actemra®**	☐ 80mg/4mL Vial ☐ 200mg/10mL Vial ☐ 400mg/20mL Vial ☐ 162mg/0.9mL ACTPen Auto-injector ☐ 162mg/0.9mL Prefilled Syringe	**IV:** ☐ **Starter Dose:** Infuse ____ mg (4 mg/kg) IV once every 4 weeks ☐ **Maintenance Dose:** Infuse ____ mg (8 mg/kg) IV once every 4 weeks (800 mg maximum dose) ☐ **Other:**_____ **SUBQ:** ☐ Inject 162mg SQ once every other week (<100 kg) ☐ Inject 162mg SQ once every week (≥100 kg)		
☐**Cimzia®**	☐ 200mg/mL Prefilled Syringe ☐ 200mg/mL Syringe Kit (2 doses) ☐ 200mg/mL Starter Kit (6 doses)	☐ **Starter Dose:** Inject 400mg SQ on Day 0, Day 14, and Day 28 ☐ **Maintenance Dose:** Inject 200mg SQ every other week ☐ **Other:**_____		
☐**Cosentyx®**	☐ 75mg/0.5mL Prefilled Syringe ☐ 150mg/mL Prefilled Syringe ☐ 150mg/mL Sensoready Auto-Injector Pen	☐ **Starter Dose:** Inject 150mg SQ at weeks, 0, 1, 2, 3, and 4 and every 4 weeks thereafter ☐ **Starter Dose:** Inject 300mg SQ once weekly at weeks 0, 1, 2, 3, and 4 followed by 300mg every 4 weeks ☐ **Maintenance Dose:** Inject 150mg SQ every 4 weeks ☐ **Maintenance Dose:** Inject 300mg SQ every 4 weeks ☐ **Other:**_____		
☐**Enbrel®**	☐ 25mg/0.5mL Vial ☐ 25mg/0.5mL Prefilled Syringe ☐ 50mg/mL Prefilled Syringe ☐ 50mg/mL SureClick Auto-injector ☐ 50mg/mL Mini Cartridge	☐ Inject 50mg SQ once weekly ☐ Inject 25 mg SQ twice weekly ☐ **Other:**_____		
☐**Humira®**	☐ 40mg/0.8mL Prefilled Syringe (2 doses) ☐ 40mg/0.8mL Pen-Injector (2 doses) ☐ CF 40mg/0.4mL Pen-Injector (2 doses) ☐ CF 40mg/0.4mL Prefilled Syringe (2 doses)	☐ **Starter/Maintenance Dose:** Inject 40mg SQ every other week ☐ **Maintenance Dose:** Inject 40mg SQ every week ☐ **Maintenance Dose:** Inject 80mg every other week ☐ **Other:**_____		
☐**Kevzara®**	☐ 150mg/1.14mL Auto-Injector ☐ 200mg/1.14mL Auto-Injector ☐ 150mg/1.14mL Prefilled Syringe ☐ 200mg/1.14mL Prefilled Syringe	☐ Inject 200mg SQ once every 2 weeks ☐ **Other:**_____		
☐**Kineret®**	☐ 100mg/0.67mL Prefilled Syringe	☐ Inject 100mg SQ once daily at approximately the same time each day		

DELIVERY INFORMATION

Need by: _____ Deliver to: ☐ Patient's home ☐ MD Office/ Clinic ☐ Other:_____

PRESCRIBER'S SIGNATURE REQUIRED

MD | NP | PA Signature:_____ ☐ **DAW** **Date:** _____

*Signature on this form also provides consent to contact this patient's insurance provider for this prescription on the provider's behalf.

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Address: _____
City, State, Zip: _____
Home Phone: _____Cell Phone: _____
Known Allergies: _____
Height: _____ Weight: _____lbs. ☐ M ☐ F
Emergency Contact: _____
Emergency Contact Phone: _____

INSURANCE INFO. Please fax copy of ALL insurance cards *front & back

Primary Insurance: _____
City, State: _____
ID Number: _____
Group Number: _____ Rx Bin: _____
Secondary Insurance: _____
City, State: _____
ID Number: _____
Group Number: _____ Rx Bin: _____

PRESCRIBER INFORMATION

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Reason For Discontinuation:_____

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MEDICATION	DOSE/STRENGTH	SIG	QTY	REFILLS
☐**Methotrexate**	☐ 50mg/2mL Vial ☐ 250mg/10mL Vial ☐ 1 gram/40mL Vial	**Oral, SUBQ, IM:** ☐ 7.5 to 15mg once weekly. Increase dose by 2.5 to 5mg/week every 4 to 12 weeks if needed based on response (maximum: 25mg/week)		
☐**Olumiant®**	☐ 1mg tablet ☐ 2mg tablet	☐ Take 2mg PO once daily. ☐ **Other:**_____		
☐**Orencia®**	☐ 50mg/0.4mL Prefilled Syringe ☐ 87.5mg/0.7mL Prefilled Syringe ☐ 125mg/mL Prefilled Syringe ☐ 125mg/mL ClickJect Auto-injector ☐ 250mg Vial	**IV:** (weight-based dosing) <60kg: 500mg; 60-100kg: 750mg; >100kg: 1,000mg ☐ **Starter Dose:** Infuse ____ mg IV on Day 0, Day 14, and Day 28, and every 4 weeks thereafter ☐ **Maintenance Dose:** Infuse ____ mg IV every 4 weeks ☐ **Other:**_____ **SUBQ:** ☐ Inject 125mg SQ once weekly ☐ **Other:**_____		
☐**Otezla®**	☐ 30mg tablet ☐ Titration Tablet Therapy Pack (10, 20, 30 mg tablets - 55 tablets)	☐ **Tablet Therapy Pack:** Take as directed on starter package ☐ **Maintenance Dose:** Take 30mg PO twice daily ☐ **Other:**_____		
☐**Otrexup®**	☐ 10mg/0.4mL Auto-injector ☐ 12.5mg/0.4mL Auto-injector ☐ 15mg/0.4mL Auto-injector ☐ 17.5mg/0.4mL Auto-injector ☐ 20mg/0.4mL Auto-injector ☐ 22.5mg/0.4mL Auto-injector ☐ 25mg/0.4mL Auto-injector	☐ Inject ____ mg SQ once weekly ☐ **Other:**_____		
☐**Rasuvo®**	☐ 7.5mg/0.15mL Auto-injector ☐ 10mg/0.2mL Auto-injector ☐ 12.5mg/0.25mL Auto-injector ☐ 15mg/0.3mL Auto-injector ☐ 17.5mg/0.35mL Auto-injector ☐ 20mg/0.4mL Auto-injector ☐ 22.5mg/0.45mL Auto-injector ☐ 25mg/0.5mL Auto-injector ☐ 30mg/0.6mL Auto-injector	☐ Inject ____ mg SQ once weekly ☐ **Other:**_____		

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SSN: _____
Address: _____
City, State, Zip: _____
Home Phone: _____Cell Phone: _____
Known Allergies: _____
Height: _____ Weight: _____lbs. ☐ M ☐ F
Emergency Contact: _____
Emergency Contact Phone: _____

INSURANCE INFO. Please fax copy of ALL insurance cards *front & back

Primary Insurance: _____
City, State: _____
ID Number: _____
Group Number: _____ Rx Bin: _____
Secondary Insurance: _____
City, State: _____
ID Number: _____
Group Number: _____ Rx Bin: _____

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Prescriber Name: _____ License: _____ DEA: _____
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MEDICATION	DOSE/STRENGTH	SIG	QTY	REFILLS
☐**Remicade®**	☐ 100mg Vial	☐ **Starter Dose:** Infuse ____ mg (3mg/kg) IV at 0, 2, and 6 weeks ☐ **Maintenance Dose:** Infuse ____ mg (3mg/kg) IV every 8 weeks ☐ **Other:**_____		
☐**Rinvoq®**	☐ 15mg Tablet - 24 Hour Extended Release ☐ 30mg Tablet - 24 Hour Extended Release	☐ Take 15 mg ER PO once daily ☐ **Other:**_____		
☐**Rituxan®**	☐ 100mg/10mL Vial	☐ **Starter Dose:** Infuse 1g IV once every 2 weeks for 2 doses ☐ **Maintenance Dose:** Infuse 1g IV once every 2 weeks for 2 doses every 24 weeks, no sooner than 16 weeks ☐ **Other:**_____		
☐**Simponi®**	☐ 50mg/4mL Aria IV Solution ☐ 50mg/0.5mL Auto-injector ☐ 50mg/0.5mL Prefilled Syringe ☐ 100mg/mL Auto-injector ☐ 100mg/mL Prefilled Syringe	**IV:** ☐ **Starter Dose:** Infuse 2mg/kg IV at weeks 0, 4, and then every 8 weeks thereafter ☐ **Maintenance Dose:** Infuse 2mg/kg IV every 8 weeks **SUBQ:** ☐ Inject 50mg SQ once a month ☐ **Other:**_____		
☐**Stelara®**	☐ 45mg/0.5mL Vial ☐ 45mg/0.5mL Prefilled Syringe ☐ 90mg/mL Prefilled Syringe ☐ 130mg/26mL Vial	☐ **Starter Dose:** Inject 45mg SQ at 0 and 4 weeks, and then every 12 weeks thereafter ☐ **Starter Dose:** Inject 90mg SQ at 0 and 4 weeks, and then every 12 weeks thereafter ☐ **Maintenance Dose:** Inject 45 mg SQ every 12 weeks ☐ **Maintenance Dose:** Inject 90 mg SQ every 12 weeks ☐ **Other:**_____		
☐**Taltz®**	☐ 80mg/1mL Auto-injector ☐ 80mg/1mL Prefilled Syringe	☐ **Starter Dose:** Inject 160mg SQ on Day 1 and 80mg on Day 29 ☐ **Maintenance Dose:** Inject 80mg SQ every 4 weeks ☐ **Other:**_____		
☐**Tremfya®**	☐ 100mg/1mL Pen-Injector ☐ 100mg/1mL Prefilled Syringe	☐ **Starter Dose:** Inject 100mg SQ at weeks 0, 4, and then every 8 weeks thereafter ☐ **Maintenance Dose:** Inject 100mg every 8 weeks ☐ **Other:**_____		
☐**Xeljanz®** ☐**Xeljanz XR®**	☐ 5mg Tablet ☐ 10mg Tablet ☐ XR 11mg Tablet ☐ XR 22mg Tablet	☐ **IR Tablet:** Take 5mg PO twice daily ☐ **XR Tablet:** Take 11mg PO once daily ☐ **Other:**_____		

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