UnityPoint at Home

SPECIALTY PHARMACY
Phone: 1 (877) 804-2713
Fax: 1 (855) 806-7285

RHEUMATOLOGY PRESCRIPTION AND REFERRAL FORM

PATIENT INFORMATION

Please send a copy of ALL of patient's insurance cards including Prescription, Primary and Secondary (both sides)
Also include any other beneficial information for prior authorization and dispensing assessments.

Patient Name _____ **DOB** _____ **Gender** ☐ Male ☐ Female

Address _____ **City** _____ **State** _____ **Zip** _____

Home Phone _____ **Cell Phone** _____ **Work phone** _____ **Email** _____

Primary Language ☐ English ☐ Spanish ☐ Other specify_____ **Allergies** _____

DIAGNOSIS / CLINICAL INFORMATION / PATIENT HISTORY (PLEASE SUBMIT SUPPORTING DOCUMENTATION)

☐ M06.9 Rheumatoid Arthritis, unspecified
☐ M08.00 Unspecified juvenile rheumatoid arthritis of unspecified site
☐ M08.03 Juvenile rheumatoid polyarthritis (seronegative)
☐ M45.9 Ankylosing spondylitis of unspecified sites in spine
☐ L40.59 Other Psoriatic Arthropathy
☐ ICD-10 Code: _____ Other Diagnosis:_____

Height: _____ (in / cm) Weight: _____ (lb / kg)
Date of labs obtained: _____ SCr:_____
TB Test Result: ☐ Neg ☐ Pos Date: _____
Active Infection: ☐ No ☐ Yes
Prior Therapy: _____
_____

PRESCRIPTION INFORMATION – Additional Information : ☐ New Start ☐ Reauthorization ☐ Restart

☐ **Actemra®** (Tocilizumab) ☒ 162 mg Prefilled Syringe
Sig: ☐ Inject 162 mg sub-q ONCE weekly
☐ Inject 162 mg sub-q ONCE every OTHER week
Disp. 1 month supply Refills: #

☐ **Cimzia®** (Certolizumab Pegol) ☐ 200 mg Prefilled Syringe ☐ 200 mg Lyophilized Vial ☐ Starter Kit
Sig: ☐ Inject 400 mg sub-q ONCE at weeks 0, 2 and 4 Disp. 1 month supply No Refills
☐ Inject 200 mg sub-q ONCE every two weeks
☐ Inject 400 mg sub-q ONCE every four weeks Disp. 1 month supply Refills: #___

☐ **Cosentyx®** (Secukinumab) ☐ 150mg Prefilled Syringe ☐ 150mg Pen
Sig: ☐ Inject 150 mg sub-q ONCE at weeks 0, 1, 2, 3, and 4 Disp. 1 month supply No Refills
☐ Inject 150 mg sub-q ONCE every FOUR weeks Disp. 1 month supply Refills: # ___

☐ **Enbrel®** (Etanercept) ☐ 25mg Vial ☐ 25mg ☐ 50mg Prefilled Syringe ☐ 50mg SureClick™ Autoinjector
Sig: ☐ Inject 50mg sub-q ONCE weekly
☐ Inject 25mg sub-q TWICE a week (72-96 hours apart) Disp. 1 month supply Refills: #___

☐ **Humira®** (Adalimumab) ☐ 40mg/0.8ml Pen ☐ 40mg/0.8ml Prefilled Syringe
Sig: ☐ Inject 40mg sub-q ONCE weekly
☐ Inject 40mg sub-q every OTHER week Disp. 1 month supply Refills: #___

☐ **Kevzara®** (Sarilumab) ☐ 200 mg Prefilled Syringe ☐ 150 mg Prefilled Syringe
Sig: ☐ Inject 200 mg sub-q ONCE every two weeks
☐ Inject 150 mg sub-q ONCE every two weeks Disp. 1 month supply Refills: #___

☐ **Kineret®** (Anakinra) ☒ 100 mg Prefilled Syringe
Sig: ☒ Inject 100mg sub-q ONCE daily Disp. 1 month supply Refills: #___

☐ **Orencia®** (Abatacept) ☐ 125 mg Prefilled Syringe ☐ 125 mg Clickject™ Autoinjector
Sig: ☒ Inject 125mg sub-q ONCE weekly Disp. 1 month supply Refills: #___

☐ **Simponi®** (Golimumab) ☐ 50 mg Prefilled Syringe ☐ 50 mg Smartject™ Autoinjector
Sig: ☒ Inject 50mg sub-q ONCE every four weeks Disp. 1 month supply Refills: #___

☐ **Xeljanz®** (Tofacitinib Citrate) ☒ 5 mg Tablet
Sig: ☒ Take one tablet by mouth twice daily Disp. 1 month supply Refills: # ___

☐ **Xeljanz XR®** (Tofacitinib Citrate) ☒ 11 mg Tablet
Sig: ☒ Take one tablet by mouth once daily Disp. 1 month supply Refills: #___

BY SIGNING BELOW, I CERTIFY THAT THE ABOVE THERAPY IS MEDICALLY NECESSARY.

If shipped to physician's office, physician accepts on behalf of patient for administration in office.

Prescriber's Signature: (No Stamps)		**DATE:**	

Print Prescriber's Name:_____ NPI: _____ Phone _____

Address _____ City_____ State _____ Fax _____