PEDIATRIC RHEUMATOLOGY

SPECIALTY PHARMACY

New Orleans, LA toll free 888.355.4191 toll free fax 888.355.4192

krogerspecialtypharmacy.com

DATE: _____ NEEDS BY DATE: _____ SHIP TO: ❑ PATIENT ❑ OFFICE ❑ OTHER _____

PATIENT INFO

Patient Name		
Address		
City, State, Zip		
Main Phone	Alternate Phone	
Social Security #	Weight (lbs)	Height
Date of Birth	❑ Male ❑ Female	

PRESCRIBER INFO

Prescriber Name		
DEA #	NPI #	License #
Address		
City, State, Zip		
Phone	Fax	
Contact Person		

PLEASE FAX COPY OF: ❑ PRESCRIPTION CARD FRONT & BACK ❑ CLINICAL NOTES ❑ MEDICAL CARD FRONT & BACK

CLINICAL INFORMATION

Diagnosis: ❑ M08.3 Juvenile Idiopathic Arthritis ❑ Other: _____ DX Code: _____

Location: **Joints:** ❑ Hands ❑ Feet ❑ Knees ❑ Spine ❑ Other _____

Drug Allergies: _____

Prior Failed Meds:
❑ _____ Length of Treatment _____ ❑ Reason for Discontinuing _____
❑ _____ Length of Treatment _____ ❑ Reason for Discontinuing _____
❑ _____ Length of Treatment _____ ❑ Reason for Discontinuing _____

Does patient have a latex allergy? ❑ Yes ❑ No **TB/PPD Test given (or intended to be given before biologic started)?** ❑ Yes ❑ No **(PLEASE send LAB result)**

PRESCRIPTION INFORMATION			QUANTITY	REFILLS
❑ Actemra®	162mg PFS	❑ Inject 162mg subcutaneously once every 3 weeks (< 30kg weight) ❑ Inject 162mg subcutaneously once every 2 weeks (≥ 30kg weight)	4 week supply	_____
❑ Enbrel®	25mg Vial	Inject 0.8mg subcutaneously weekly (maximum of 50mg per week)	4 week supply	_____
❑ Humira® Citrate Free	❑ 10mg PFS ❑ 20mg PFS ❑ 40mg PFS	Inject 10mg subcutaneously every other week (10kg (22lbs) to <15kg (33lbs) Inject 20mg subcutaneously every other week (15kg (33lbs) to < 30kg (66lbs) Inject 40mg subcutaneously every other week (≥ 30kg (66lbs)	4 week supply	_____
❑ Orencia®	❑ 50mg PFS ❑ 87.5mg PFS ❑ 125mg PFS	Inject 50mg subcutaneously ONCE a week Inject 87.5mg subcutaneously ONCE a week Inject 125mg subcutaneously ONCE a week	4 week supply	_____
❑ Other				

By signing this form and utilizing our services, you are authorizing Kroger Specialty Pharmacy™ and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature (no stamps) Substitution Permitted Date

Prescriber's Signature (no stamps) Dispense As Written Date

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged property or exempt from disclosure under applicable law. If you are not the named addresses you should not disseminate, distribute or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.