RHEUMATOLOGY

New Orleans, LA toll free 888.355.4191 toll free fax 888.355.4192
krogerspecialtypharmacy.com

SPECIALTY PHARMACY

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)

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: ❑ M06.9 Rheumatoid Arthritis ❑ L40.50 Psoriatic Arthritis ❑ M45.9 Ankylosing Spondylitis ❑ M32.10 Systemic Lupus Erythematosus
❑ H20.9 Uveitis ❑ M08.3 Juvenile Idiopathic Arthritis ❑ Other: _____ DX Code: _____

Location: Joints: ❑ Hands ❑ Feet ❑ Knees ❑ Spine Skin: %BSA: _____ ❑ Hands ❑ Feet ❑ Scalp ❑ Groin ❑ Nails ❑ Other

Drug Allergies: _____

Prior Failed Meds: ❑ Methotrexate 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 Prefilled Syringe ❑ _____ Vial	Inject 162mg subcutaneously ❑ ONCE a week or ❑ every OTHER week Infuse _____mg at _____	4 week supply	_____
❑ Benlysta®	❑ 120mg Vial ❑ 400mg Vial 200mg ❑ Autoinjector ❑ PFS	❑ Load: Infuse _____mg at weeks 0, 2, and 4 , then every 4 weeks thereafter ❑ Maintenance: Infuse _____mg every 4 weeks Inject 200mg subcutaneously ONCE a week	4 week supply	_____
❑ Cimzia®	❑ 200x2 Prefilled Syringe ❑ 200x2 LYO Powder	❑ Starter Kit: Inject 400mg subcutaneously at weeks 0, 2 and 4 Maintenance: ❑ Inject 400mg SubQ once every 4 weeks or ❑ Inject 200mg SubQ once every 2 weeks	1 Kit 4 week supply	none _____
❑ Cosentyx®	300mg (2x150) ❑ Pen ❑ PFS 150mg ❑ Pen ❑ PFS *Covered Until You're Covered	Load: Inject ❑ 300mg or ❑ 150mg subcutaneously week 0, 1, 2, 3, 4 Maintenance: Inject ❑ 300mg or ❑ 150mg subcutaneously every 4 weeks Free Drug Load: Inject ❑ 300mg or ❑ 150mg subcutaneously week 0, 1, 2, 3, 4* Free Drug Maintenance: Inject ❑ 300mg or ❑ 150mg subcutaneously every 4 weeks*	5 week supply 4 week supply 5 week supply 4 week supply	none _____ none _____
❑ Enbrel®	50mg ❑ Sureclick ❑ PFS ❑ Mini 25mg ❑ Vial ❑ PFS	Inject 50mg subcutaneously ONCE a week Inject 25mg subcutaneously TWICE a week 72-96 hours apart	4 week supply	_____
❑ Humira® Citrate Free	❑ Uveitis Starter Kit ❑ 40mg Pen ❑ 40mg Prefilled Syringe	Inject 80mg (1 pen) on day 1, then 40mg on day 8, then 40mg every other week ❑ Inject 40mg subcutaneously every OTHER week ❑ Inject 40mg subcutaneously ONCE a week	Loading Dose 4 week supply	none _____
❑ Humira®	❑ Uveitis Starter Kit ❑ 40mg Pen ❑ 40mg Prefilled Syringe	Inject 2-40mg (80mg) on day 1, then 40mg on day 8, then 40mg every other week ❑ Inject 40mg subcutaneously every OTHER week ❑ Inject 40mg subcutaneously ONCE a week	Loading Dose 4 week supply	none _____
❑ Kevzara®	200mg ❑ Pen ❑ PFS 150mg ❑ Pen ❑ PFS	Inject 200mg subcutaneously once every 2 weeks Inject 150mg subcutaneously once every 2 weeks	4 week supply	_____
❑ Orencia®	125mg ❑ ClickJect™ ❑ PFS ❑ 250mg Vial	Inject 125mg subcutaneously ONCE a week Infuse _____mg at _____	4 week supply	_____
❑ Olumiant®	2mg Tablets	Take 1 tablet by mouth daily	30	_____
❑ Otezla®	❑ Starter Pack ❑ 30mg Tablets	❑ Titrate: Take 1 tablet on day 1 then twice daily as directed **OR date provided** _____ ❑ Maintenance: Take 1 tablet by mouth twice daily. ❑ Bridge Rx: Take 1 tablet by mouth twice daily; dispensed by OSP	1 Starter Pack 60 28	none _____ 12
❑ Remicade®	100mg Vial	Infuse _____mg at _____ wt _____	4 week supply	_____
❑ Rituxan®	_____	Infuse _____mg at _____	4 week supply	_____
❑ Simponi®	50mg ❑ SmartJect ❑ PFS ❑ Aria	Inject 50mg subcutaneously ONCE a MONTH Infuse _____mg at weeks 0 and 4, then every 8 weeks thereafter	4 week supply	_____
❑ Stelara®	45mg Prefilled Syringe	❑ Starter: Inject 45mg subcutaneously on week 0 ❑ Maintenance: Inject 45mg subcutaneously on week 4 and then every 12 weeks	1 1	none _____
❑ Taltz®	80mg ❑ Autoinjector ❑ PFS	❑ Load: Inject 2-80mg (160mg) subcutaneously on day 1 ❑ Maintenance: Inject 80mg subcutaneously every 4 weeks	2 1	none _____
❑ Xeljanz®	❑ 5mg Tablets ❑ 11mg XR Tablets	Take 1 tablet by mouth twice daily (Alternate dose: ❑ Take 1 tablet once a day #30 tabs) Take 1 tablet by mouth once daily	60 30	_____ _____
❑ 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