SPECIALTY PHARMACY

RHEUMATOLOGY

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		PRESCRIBER INFO		
Patient Name		Prescriber Name		
Address		DEA #	NPI #	License #
City, State, Zip		Address		
Main Phone	Alternate Phone	City, State, Zip		
Social Security #	Weight (lbs)	Phone	Fax	
Date of Birth	❑ Male ❑ Female	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®	❑ 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 _________
❑ 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 _________
❑ 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 ________

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04902 09-28-2018 NOLA