RHEUMATOLOGY A-M

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 INFORMATION

Patient Name	
Address	
City, State, Zip	
Main Phone	Alternate Phone
Social Security #	
Date of Birth	❑ Male ❑ Female

PRESCRIBER INFORMATION

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 ❑ Other: Dx code _____ Condition _____
Location: Joints: ❑ Hands ❑ Feet ❑ Knees ❑ Spine Skin: % BSA: _____ ❑ Hands ❑ Feet ❑ Scalp ❑ Groin ❑ Nails ❑ Other: _____
Drug Allergies: _____ Weight: _____ ❑ kg ❑ lb
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? ❑ No ❑ Yes **TB Test:** ❑ No ❑ Yes Date: _____ Results: _____ (Please send lab results)

		PRESCRIPTION INFORMATION	QUANTITY	REFILLS
❑ Actemra®	162 mg ❑ Autoinjector ❑ PFS Vials: ❑ 80mg/4mL ❑ 200mg/10mL ❑ 400mg/20mL	Inject 162mg subcutaneously ❑ ONCE a week **or** ❑ every OTHER week ❑ Infuse _____ mg (_____ mg/kg) every 4 weeks	4 Week Supply 4 Week Supply	_____ _____
❑ Benlysta®	Vials: ❑ 120mg ❑ 400mg 200mg ❑ Autoinjector ❑ PFS	❑ Load: Infuse _____ mg (10 mg/kg) at weeks 0,2, and 4, then every 4 weeks thereafter ❑ Maintenance: Infuse _____ mg (10 mg/kg) every 4 weeks Inject 200mg subcutaneously once a week	Loading Dose 4 Week Supply 4 Week Supply	None _____ _____
❑ Cimzia®	❑ 200mg x2 PFS ❑ 200mg x2 Vials	❑ Starter Kit: Inject 400mg subcutaneously at weeks 0,2, and 4 ❑ Maintenance: Inject 400mg subcutaneously every 4 weeks ❑ Maintenance: Inject 200mg subcutaneously every 2 weeks	1 Starter Kit (PFS)/6 Vials 4 Week Supply	None _____
❑ Cosentyx®	300mg *(2x150mg)* ❑ Pen ❑ PFS 150mg ❑ Pen ❑ PFS **Covered Until You're Covered*	Load: Inject ❑ 300mg **or** ❑ 150mg subcutaneously at weeks 0,1,2,3,4 Maintenance: Inject ❑ 300mg **or** ❑ 150mg subcutaneously every 4 weeks Free Drug Load: Inject ❑ 300mg **or** ❑ 150mg subcutaneously at weeks 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	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 ❑ PFS	Load: Inject 80mg on day 1, then 40mg on day 8, then 40mg every other week ❑ Maintenance: Inject 40mg subcutaneously every other week ❑ Maintenance: Inject 40mg subcutaneously once a week	Loading Dose 4 Week Supply	None _____
❑ Humira®	❑ Uveitis Starter Kit 40mg ❑ Pen ❑ PFS	Load: Inject 80mg (as two-40mg injections) on day 1, then 40mg on day 8, then 40mg every other week ❑ Maintenance: Inject 40mg subcutaneously every other week ❑ Maintenance: Inject 40mg subcutaneously once a week	Loading Dose 4 Week Supply	None _____
❑ Kevzara®	200mg ❑ Pen ❑ PFS 150mg ❑ Pen ❑ PFS	Inject 200mg subcutaneously every 2 weeks Inject 150mg subcutaneously every 2 weeks	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

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