# RHEUMATOLOGY N-Z

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 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
❑ 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 |
|---|---|---|---|---|
| ❑ Olumiant® | ❑ 2mg Tablet<br>❑ 1mg Tablet | Take 1 tablet by mouth daily | 30 Tablets | _____ |
| ❑ Orencia® | ❑ 125mg ❑ ClickJect™ ❑ PFS<br>❑ 250mg Vial | Inject 125mg subcutaneously once a week<br>❑ Load: Infuse _____ mg at weeks 0,2, and 4, then every 4 weeks thereafter<br>❑ Maintenance: Infuse _____ mg every 4 weeks | 4 Week Supply | _____ |
| ❑ Otezla® | ❑ Starter Pack<br>❑ 30mg Tablet | Take 1 tablet on day 1 then twice daily as directed **or** date provided _____<br>❑ Take 1 tablet by mouth twice daily<br>For Bridge Requests please utilize the Otezla Support Plus Start Form and fax to Kroger Specialty Pharmacy at 888.355.4192 | 1 Starter Pack<br>60 Tablets | None<br>_____ |
| ❑ Remicade® | 100mg Vial | ❑ Load: Infuse _____ mg (_____ mg/kg) at weeks 0,2, and 6<br>❑ Maintenance: Infuse _____ mg (_____ mg/kg) every _____ weeks | Loading Dose<br>❑ 6 **or** ❑ 8 Week Supply | None<br>_____ |
| ❑ Rinvoq™ | 15mg ER Tablet | Take 1 tablet by mouth daily | 30 Tablets | _____ |
| ❑ Rituxan® | 500mg/50mL Vial | Infuse 1000mg on days 1 and 15, repeat cycle in _____ weeks | 4 Vials | _____ |
| ❑ Simponi® | 50mg ❑ SmartJect® ❑ PFS<br>❑ 50mg/4mL Aria® Vial | Inject 50mg subcutaneously once a month<br>❑ Load: Infuse _____ mg (2mg/kg) at weeks 0 and 4, then every 8 weeks thereafter<br>❑ Maintenance: Infuse _____ mg (2mg/kg) every 8 weeks | 4 Week Supply<br>Loading Dose<br>8 Week Supply | _____<br>None<br>_____ |
| ❑ Stelara® | 45mg PFS | ❑ Starter: Inject 1 syringe subcutaneously on week 0<br>❑ Maintenance: Inject 1 syringe subcutaneously on week 4, and then every 12 weeks thereafter | 1 Syringe<br>1 Syringe | None<br>_____ |
| ❑ Taltz® | 80mg ❑ Autoinjector ❑ PFS | ❑ Load: Inject 160mg (as two-80mg injections) subcutaneously on day 1 and then 80mg every 4 weeks thereafter<br>❑ Maintenance: Inject 80mg subcutaneously every 4 weeks | Loading Dose<br>4 Week Supply | None<br>_____ |
| ❑ Xeljanz® | ❑ 5mg Tablet<br>❑ 11mg XR Tablet | Take 1 tablet by mouth twice daily<br>Take 1 tablet by mouth daily | 60 Tablets<br>30 Tablets | _____<br>_____ |
| ❑ 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