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 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: ❑ M08.0 Juvenile Idiopathic Arthritis ❑ H20.9 Uveitis ❑ Other: Dx code _____ Condition _____
Location: Joints: ❑ Hands ❑ Feet ❑ Knees ❑ Spine ❑ 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®	162mg ❑ Autoinjector ❑ PFS Vials: ❑ 80mg/4mL ❑ 200mg/10mL ❑ 400mg/20mL	**Polyarticular Juvenile Idiopathic Arthritis** *Subcutaneous:* ❑ Inject 162mg subcutaneously every 3 weeks (<30kg) ❑ Inject 162mg subcutaneously every 2 weeks (≥30kg) *Intravenous:* ❑ Infuse _____ mg (10mg/kg) every 4 weeks (<30kg) ❑ Infuse _____ mg (8mg/kg) every 4 weeks (≥30kg) **Systemic Juvenile Idiopathic Arthritis** *Subcutaneous:* ❑ Inject 162mg subcutaneously every 2 weeks (<30kg) ❑ Inject 162mg subcutaneously every week (≥30kg) *Intravenous:* ❑ Infuse _____ mg (12mg/kg) every 2 weeks (<30kg) ❑ Infuse _____ mg (8mg/kg) every 2 weeks (≥30kg)	4 Week Supply	_____
❑ Benlysta®	200mg ❑ Autoinjector ❑ PFS Vials: ❑ 120mg ❑ 400mg	Inject 200mg subcutaneously once a week ❑ Load: Infuse _____ mg (10mg/kg) at weeks 0,2, and 4, then every 4 weeks thereafter ❑ Maintenance: Infuse _____ mg (10mg/kg) every 4 weeks	4 Week Supply Loading Dose 4 Week Supply	_____ None _____
❑ Enbrel®	50mg ❑ SureClick® ❑ PFS ❑ Mini ❑ 25mg Vial ❑ 25mg PFS	Inject 50mg subcutaneously once a week (≥63kg) Inject _____ mg (0.8mg/kg) subcutaneously once a week (<63kg) Inject 25mg subcutaneously once a week	4 Week Supply	_____
❑ Humira® Citrate Free	❑ 10mg PFS ❑ 20mg PFS 40mg ❑ PFS ❑ Pen	Inject 10mg subcutaneously every other week (10kg to< 15kg) Inject 20mg subcutaneously every other week (15kg to <30kg) Inject 40mg subcutaneously every other week (≥30kg)	4 Week Supply	_____
❑ Orencia®	❑ 50mg PFS ❑ 87.5mg PFS ❑ 125mg PFS ❑ 250mg Vial	Inject 50mg subcutaneously weekly (10kg to < 25kg) Inject 87.5mg subcutaneously weekly (25kg to <50kg) Inject 125mg subcutaneously weekly (≥50kg) ❑ Load: Infuse 1000mg IV at weeks 0, 2, 4, then every 4 weeks thereafter (>100kg) ❑ Load: Infuse 750mg IV at weeks 0, 2, 4, then every 4 weeks thereafter (75kg to 100kg) ❑ Load: Infuse _____ mg (10mg/kg) IV at weeks 0, 2, 4, then every 4 weeks thereafter (<75kg) ❑ Maintenance: Infuse _____ mg IV every 4 weeks	4 Week Supply Loading Dose 4 Week Supply	_____ None _____
❑ 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