



Patient Referral/Medication Request Psoriasis/Rheumatoid/Psoriatic Arthritis Therapy

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Today's Date:

Anticipated Start Date:

PATIENT INFORMATION															
First Name:		Last Name:													
Address:		City:	State: ZIP:												
Home Phone:		Work Phone:	Cell Phone:												
DOB:	Height:	Weight:	Allergies:												
Ship Meds to: <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Doctor's Office		Email Address:													
INSURANCE INFORMATION															
Primary Insurance:		Pharmacy Benefit Manager (PBM):													
Policy #:	Group #:	Insured:	Phone:												
Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, provide #:	Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, provide #:												
Secondary Insurance:															
Policy #:	Group #:	Insured:	Phone:												
PHYSICIAN INFORMATION															
First Name:		Last Name: M.D./D.O.													
Address:		City:	State: ZIP:												
Phone:	Fax:	St Lic #:	NPI #: DEA #: UPIN:												
Office Contact Name:		Email Address: Phone:													
DIAGNOSIS:															
Primary:		ICD 9:	Secondary: ICD 9:												
PRESCRIPTION (Please select from below and provide approximate days supply.)															
<input type="checkbox"/> ENBREL # of Refills _____ <input type="checkbox"/> Enbrel 25mg <input type="checkbox"/> PFS <input type="checkbox"/> Vials (4/bx) qty _____ boxes <input type="checkbox"/> Sig: Inject 25mg SQ <input type="checkbox"/> Weekly <input type="checkbox"/> Twice Weekly <input type="checkbox"/> Other: _____ <input type="checkbox"/> Enbrel 50mg <input type="checkbox"/> PFS <input type="checkbox"/> Sureclick (4/bx) qty _____ boxes <input type="checkbox"/> Sig: Inject 50mg SQ <input type="checkbox"/> Weekly <input type="checkbox"/> Twice Weekly <input type="checkbox"/> Other: _____		<input type="checkbox"/> HUMIRA # of Refills _____ <input type="checkbox"/> Humira Psoriasis Starter Pak (4 Pens/pk) qty _____ paks <input type="checkbox"/> Humira 40mg (2 pre-filled syringes/bx) qty _____ boxes <input type="checkbox"/> Humira 40mg (2 pens/bx) qty _____ boxes <input type="checkbox"/> Humira 20mg (2 pre-filled syringes/bx) qty _____ boxes Directions: <input type="checkbox"/> Initial (Psoriasis): _____ <input type="checkbox"/> Inject 80mg as a single dose followed by 40mg SQ every other week beginning one week after initial dose <input type="checkbox"/> Inject 40mg SQ every other week <input type="checkbox"/> Other: _____													
<input type="checkbox"/> REMICADE # of Refills _____ Patient's Current Weight: _____ lbs/kg (REQUIRED) Dose per kg: _____ Per each infusion: <input type="checkbox"/> Remicade 100mg vials qty _____ vials <input type="checkbox"/> Excel Sodium Chloride 250ml 0.9% qty _____ bags <input type="checkbox"/> Sterile H ₂ O for injection 10m/vial qty _____ vials <input type="checkbox"/> NS Flush 10mL/PFS qty _____ syringes <input type="checkbox"/> Epipen® <input type="checkbox"/> Benadryl® 50mg vial PRN allergic reaction Directions: <input type="checkbox"/> initial IV week: 0,2,6. <input type="checkbox"/> Other: _____		<input type="checkbox"/> ORENCIA # of Refills _____ Patient's Current Weight: _____ lbs/kg (REQUIRED) <input type="checkbox"/> Orenzia 250mg vials <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr style="background-color: #f2f2f2;"> <th>BODY WEIGHT OF PATIENT</th> <th>DOSE:</th> <th>NUMBER OF VIALS*</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> <60 kg</td> <td>500 mg</td> <td>2</td> </tr> <tr> <td><input type="checkbox"/> 60 to 100 kg</td> <td>750 mg</td> <td>3</td> </tr> <tr> <td><input type="checkbox"/> >100 kg</td> <td>1 gram</td> <td>4</td> </tr> </tbody> </table> *Each vial provides 250mg of abatacept for administration. Per each infusion: <input type="checkbox"/> 100ml Sodium Chloride Injectable 0.9% IV bag <input type="checkbox"/> Sterile H ₂ O 10 mL/vial qty _____ vials <input type="checkbox"/> NS Flush 10mL/PFS qty _____ syringes <input type="checkbox"/> Epipen® <input type="checkbox"/> Benadryl® 50mg vial PRN allergic reaction Directions: <input type="checkbox"/> Initial dose: IV at Weeks 0, 2, 4 <input type="checkbox"/> Maintenance dose: IV every 4 weeks <input type="checkbox"/> Other: _____		BODY WEIGHT OF PATIENT	DOSE:	NUMBER OF VIALS*	<input type="checkbox"/> <60 kg	500 mg	2	<input type="checkbox"/> 60 to 100 kg	750 mg	3	<input type="checkbox"/> >100 kg	1 gram	4
BODY WEIGHT OF PATIENT	DOSE:	NUMBER OF VIALS*													
<input type="checkbox"/> <60 kg	500 mg	2													
<input type="checkbox"/> 60 to 100 kg	750 mg	3													
<input type="checkbox"/> >100 kg	1 gram	4													
<input type="checkbox"/> CIMZIA # of Refills _____ <input type="checkbox"/> Cimzia 200mg <input type="checkbox"/> PFS <input type="checkbox"/> Vials (2/bx) qty _____ boxes Directions: <input type="checkbox"/> Initial dose: 400mg SQ at week 0, week 2 and week 4 <input type="checkbox"/> Maintenance dose: 400mg SQ every 4 weeks <input type="checkbox"/> 200mg SQ every 2 weeks <input type="checkbox"/> Other: _____		<input type="checkbox"/> ORENCIA SC # of Refills _____ <input type="checkbox"/> 125mg/mL (4pfs/bx) qty _____ boxes Directions: _____													
<input type="checkbox"/> RITUXAN THIS IS FOR INFORMATIONAL PURPOSES ONLY. RITUXAN REQUIRES PRECERT. PLEASE REFER TO THE RITUXAN PRECERTIFICATION REQUEST FORM. http://www.aetna.com/provider/data/68535_Rituxan_Precert_Form.pdf		<input type="checkbox"/> KINERET # of Refills _____ <input type="checkbox"/> Kineret 100mg (28 syringes/bx) qty _____ boxes Directions: <input type="checkbox"/> Inject 100mg SQ daily <input type="checkbox"/> Other: _____													
Prescriber's Signature Required by Law: _____ Date: / /															

Interchange is mandated unless practitioner writes the words "NO SUBSTITUTION" in this space.
Incomplete information may result in therapy delay. Please complete all fields.



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Patient's Name: _____ DOB: _____

PRESCRIPTION-continued (Please select from below and provide approximate days supply.)

<input type="checkbox"/> ACTEMRA # of Refills _____ Patient's Current Weight: _____ lbs/kg (REQUIRED) Directions: <input type="checkbox"/> Infuse _____ mg/kg IV q 4 weeks <input type="checkbox"/> Other: _____	<input type="checkbox"/> STELARA # of Refills _____ Patient's Current Weight: _____ lbs/kg (REQUIRED) <input type="checkbox"/> 45mg pre-filled syringe qty _____ <input type="checkbox"/> 90mg pre-filled syringe qty _____ Directions (Initial): <input type="checkbox"/> ≤ 100kg: Inject 45mg SQ at week 0 and week 4, then q 12 weeks thereafter <input type="checkbox"/> >100kg: Inject 90mg SQ at week 0 and week 4, then q 12 weeks thereafter <input type="checkbox"/> Other: _____ Maintenance: <input type="checkbox"/> Inject 45mg SQ q 12 weeks <input type="checkbox"/> Inject 90mg SQ q 12 weeks <input type="checkbox"/> Other: _____
<input type="checkbox"/> AMEVIVE # of Refills _____ <input type="checkbox"/> 15 mg vials (4/bx) qty _____ boxes Directions: <input type="checkbox"/> Inject 15mg IM Weekly <input type="checkbox"/> Other: _____	<input type="checkbox"/> OTHER DRUG: _____ Strength _____ Frequency: _____ Route: _____ # of Refills _____ Directions: _____
<input type="checkbox"/> SIMPONI # of Refills _____ <input type="checkbox"/> 50mg/0.5 SmartJect syringe qty _____ <input type="checkbox"/> 50mg/0.5ml pre-filled syringe qty _____ Directions: <input type="checkbox"/> Inject 50 mg SQ Monthly <input type="checkbox"/> Other: _____	
<input type="checkbox"/> METHOTREXATE # of Refills _____ <input type="checkbox"/> 25mg/ml 2 ml vial qty _____ <input type="checkbox"/> Dose: _____ Directions: <input type="checkbox"/> Weekly <input type="checkbox"/> Route: <input type="checkbox"/> SQ <input type="checkbox"/> IM (please indicate route of administration) <input type="checkbox"/> Other: _____	

Prescriber's Signature Required by Law: _____ Date: ____ / ____ / ____

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