

Patient Information			PLEASE FAX INSURANCE CARD (FRONT AND BACK)			Prescriber Information		
Last Name	First Name	DOB	Practice/Facility Name					
Address			Address					
City	State	ZIP	City	State	ZIP			
SSN			Prescriber Name					
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Weight (kg)	Height (ft.in)	Prescriber NPI					
Emergency Contact		Phone	Nurse/Key Contact		Phone/Pager			
Insurance Plan		Plan ID #	Fax					

Diagnosis/Clinical Information				PLEASE FAX CLINICAL AND LAB INFORMATION			
Primary Diagnosis:	M06.9 Rheumatoid Arthritis	M08.00 Juvenile Rheumatoid Arthritis	L40.59 Psoriatic Arthritis				
	L40.54 Psoriatic Juvenile Arthritis	M45.9 Ankylosing Spondylitis	Other: _____				
Date of diagnosis/years with the disease:	_____						
Prior Therapy:	No	Yes (provide details): _____					
Concurrent Therapy:	No	Yes (provide details): _____					
TB Test:	No	Yes (date): _____	Results:	_____			

Prescription Information					
MEDICATION	DOSE/STRENGTH	DIRECTIONS FOR USE	QTY	Refills	
Simponi®	50 mg/0.5 ml SmartJect® Pen 50 mg/0.5 ml PFS	Inject 50mg SC once a month	1		
Simponi Aria® Current Weight: _____kg	50 mg/4 ml Vial	Initial Dose: Infuse 2 mg/kg (____mg) over 30 minutes at week 0 Maintenance Dose: Infuse 2 mg/kg (____mg) over 30 minutes at week 4 and then every 8 weeks thereafter	QS		0
Stelara Current Weight: _____kg <small>(recommended dose for coexistent PsA & PsO in patients >100kg = 90mg)</small>	45 mg/0.5 ml PFS 90 mg/1 ml PFS	Initial Dose: Inject 45 mg SC on day 1 Inject 90 mg SC on day 1 Maintenance Dose: Inject 45 mg SC on day 29 and every 12 weeks thereafter Inject 90 mg SC on day 29 and every 12 weeks thereafter	1		0
Taltz® <small>(recommended dosing for PsA)</small>	80 mg/ml Auto-injector 80 mg/ml Prefilled syringe	Initial Dose: Inject 160 mg (2-80 mg) SQ on day 1 Maintenance Dose: Inject 80 mg SQ on day 28 and every 4 weeks thereafter	2		0
Xatmep® _____kg <small>(dosing for pJIA)</small>	2.5 mg/ml oral solution	Take _____mg one time weekly	4 week supply		
Xeljanz®	5 mg tablet	Take one tablet by mouth once daily	30		
		Take one tablet by mouth twice daily	60		
Xeljanz XR®	11 mg XR tablet	Take one tablet by mouth once daily	30		

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary," or your state-specific required language to prohibit substitution: _____

PRODUCT SUBSTITUTION PERMITTED/Brand exchange permitted (date)

DISPENSE AS WRITTEN/Do Not Substitute (date)

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