HOME PARENTERAL SERVICES

PHONE: 1-800-637-9201
FAX: 1-417-269-0692

Rheumatology (A-E)

(Cimzia®, Cosentyx®, Enbrel®)

Patient Information

Patient name: _____ DOB: _____

Sex: ❑ Female ❑ Male SSN: _____

Language: _____ Wt: _____ ❑kg ❑lbs Ht: _____ ❑cm ❑in

Address: _____

Apt/Suite: _____ City: _____ State: _____ Zip: _____

Phone: _____ Alternate: _____

Caregiver name: _____ Relation: _____

Local pharmacy: _____ ___ Phone: _____

Insurance plan: _____ Plan ID: _____

Please fax a copy of front and back of the insurance card(s).

Prescriber + Shipping Information

Prescriber name: _____

NPI: _____

Address: _____

Apt/Suite: _____ City: _____ State: _____ Zip: _____

Contact: _____

Phone: _____ Alternate: _____

Fax: _____

Email: _____

If shipping to prescriber: ❑ First Fill ❑ Always ❑Never

Clinical Information (Please fax all pertinent clinical and lab information)

Diagnosis: ❑ M06.9 (Rheumatoid Arthritis) ❑ M08.0 (Juvenille Idiopathic Arthritis) ❑ L40.59 (Psoriatic Arthritis)

❑ M45.9 (Ankylosing Spondylitis) ❑ _____

Diagnosis Date: _____ _____ TB test: Yes No Negative Test Date: _____ _____ ___

Prior Therapy	Yes	No	Reason for Discontinuation of Therapy	Approximate Start Date	Approximate End Date
_____		___	_____	_____ __	_____ __
_____		___	_____	_____ __	_____ __
_____		___	_____	_____ __	_____ __

Comorbidities: _____ _____

Concomitant Medications: _____ _____ _____ _____

Allergies: NKDA Other: _____ _____ _____

Prescription		Quantity		Refill
❑ **Cimzia® ≥ (certolizumab)**	❑ Inject 400 mg subq at weeks 0,2 and 4	6 x 200 mg/mL	❑ PFS ❑ Vials	0
	❑ Inject 200 mg subq every 2 weeks ❑ Inject 400 mg subq every 4 weeks	2 x 200 mg/mL	❑ PFS ❑ Vials	_____
❑ **Cosentyx® (secukinumab)**	❑ Inject 150 mg subq once weekly at weeks 0, 1, 2 and 3	4 x 150 mg/mL	❑ Sensoready® Pen ❑ PFS	0
	❑ Inject 300 mg subq once weekly at weeks 0, 1, 2 and 3	8 X 150 mg/mL		
	❑ Inject 150 mg subq once weekly at week 4 and every 4 weeks thereafter	1 x 150 mg/mL	❑ Sensoready® Pen ❑ PFS	_____
	❑ Inject 300 mg subq once weekly at week 4 and every 4 weeks thereafter	2 x 150 mg/mL		
❑ **Enbrel® (etanercept)**	❑ Inject 50 mg subq every week	4 x 50 mg/mL	❑ SureClick® Autoinjector ❑ PFS ❑ Vials	_____
	❑ Inject _____ mg (0.8 mg/kg x _____ kg) subq every week	____ x 25 mg/mL		

§ Actemra® is located on seperate form§

§ Humira®, Kevzara®, Orencia®, Otezla® are available on the Rheumatology Enrollment Form F-R §

§ Simponi®, Simponi Aria®, Stelara®, Taltz®, Xeljanz®, Xeljanz®XR are available on the Rheumatology Enrollment Form S-Z §

Injection Training Provided by: ❑ Prescriber 's Office ❑ HPS, skilled nursing visits to teach self administrationof SQ injection and PRN if needed ❑ Other: _____

Prescriber's Signature: _____ _____ Date: _____

Substitution Permitted Dispense as Written

I authorize Home Parenteral Services and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time by providing written notice to Home Parenteral Services.

Confidentiality Statement: This message is intended only for the individual or entity to which it is addressed. It may contain information which may be proprietary and confidential. It may also contain privileged, confidential information which is exempt from disclosure underapplicable laws, including the Health Insurance Portability and Accountability Act (HIPAA). If you are not the intended recipient, please note that you are strictly prohibited from disseminating or distributing this information (other than to the intended recipient) or copying thisinformation. If you received this communication in error, please notify the sender immediately by calling 1-800-637-9201 to obtain instructions as to the proper destruction of the transmitted material. Thank you.