HOME PARENTERAL SERVICES

Rheumatology (F- R)

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

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 phar macy: _____ ____ __ __ Phone: _____ ___
Insurance p lan: _____ _____ 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)
❑ L40.54 (Psoriatic Juvenille 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 Medi cations: _____ _____ _____ _____
Allergies: NKDA Other: _____ _____ _____

Prescription		Quantity		Refill
❑**Humira® citrate free (adalimumab)**	Inject 40mg subq every other week	2 x 40mg/0.4mL	Pens	_____
❑ **Kevzara® (sarilumab)**	❑Inject 150 mg subq every other week	2 x 150 mg/1.14mL	PFS	_____
	❑Inject 200 mg subq every other week	2 x 200 mg/1.14mL		
❑ **Olumiant® (baricitinib)**	Take 2mg by mouth once daily	30 x 2mg	Tablets	_____
❑**Orencia® (abatacept)**	❑ Infuse _____ mg IV at week 0, 2, 4 and every 4 weeks thereafter RA or PsA dosing: <60kg: 500mg, 60-100kg: 750mg, >100kg: 1,000mg	_____ x 250 mg	Vials	_____
	❑ Infuse _____ mg IV on week 0 **only** RA or PsA dosing: <60kg: 500mg, 60-100kg: 750mg, >100kg: 1,000mg	_____ x 250 mg	Vials	0
	❑Inject 125 mg subq once weekly	4 x 125 mg/mL	❑ PFS ❑ ClickJect™	_____
❑ **Otezla® (apremilast)**	❑Take as directed per package instructions	55 tablets	28-day starter pack	0
	❑Take 30 mg twice daily by mouth _____	60 x 30 mg tablets _____		_____

Please the following forms for additional medications: Actemra, Rheumatology A-R, Rheumatology S-Z

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

P rescriber'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.

3-26-19 Revised Date