CoxHealth at Home

PHONE: 1-855-419-4663
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 ❑ Other: ___________
❑ CoxHealth at Home, skilled nursing visits to teach self administration of SQ injection and PRN if needed

Prescriber's Signature: ____________ Date: ____________

I authorize CoxHealth at Home 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 CoxHealth at Home

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