

Patient Information	Prescriber + Shipping Information
Patient name: _____ DOB: _____ Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male SSN: _____ Language: _____ Wt: _____ <input type="checkbox"/> kg <input type="checkbox"/> lbs Ht: _____ <input type="checkbox"/> cm <input type="checkbox"/> 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 name: _____ NPI: _____ Address: _____ Apt/Suite: _____ City: _____ State: _____ Zip: _____ Contact: _____ Phone: _____ Alternate: _____ Fax: _____ Email: _____ If shipping to prescriber: <input type="checkbox"/> First Fill <input type="checkbox"/> Always <input type="checkbox"/> Never

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

Diagnosis: M06.9 (Rheumatoid Arthritis) M08.0 (Juvenile Idiopathic Arthritis) L40.59 (Psoriatic Arthritis)
 L40.54 (Psoriatic Juvenile 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	
<input type="checkbox"/> Humira® citrate free (adalimumab) Inject 40mg subq every other week	2 x 40mg/0.4mL	Pens _____	
<input type="checkbox"/> Kevzara® (sarilumab) <input type="checkbox"/> Inject 150 mg subq every other week <input type="checkbox"/> Inject 200 mg subq every other week	2 x 150 mg/1.14mL	PFS _____	
	2 x 200 mg/1.14mL		
<input type="checkbox"/> Olumiant® (baricitinib) Take 2mg by mouth once daily	30 x 2mg	Tablets _____	
<input type="checkbox"/> Orencia® (abatacept) <input type="checkbox"/> 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 _____	
	<input type="checkbox"/> Infuse _____ mg IV on week 0 only RA or PsA dosing: <60kg: 500mg, 60-100kg: 750mg, >100kg: 1,000mg	_____ x 250 mg	Vials 0
	<input type="checkbox"/> Inject 125 mg subq once weekly	4 x 125 mg/mL	<input type="checkbox"/> PFS <input type="checkbox"/> ClickJect™ _____
<input type="checkbox"/> Otezla® (apremilast) <input type="checkbox"/> Take as directed per package instructions <input type="checkbox"/> Take 30 mg twice daily by mouth	55 tablets	28-day starter pack 0	
	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 CoxHealth at Home, skilled nursing visits to teach self administration of SQ injection and PRN No training

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.