

Patient Information	Prescriber + Shipping 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: _____ <b>Please fax a copy of front and back of the insurance card(s).</b>	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**

Prescription	Quantity	Refill
<input type="checkbox"/> <b>Rinvoq (upadacitinib)</b> Take 15mg by mouth once daily	30 x 15mg tablets	_____
<input type="checkbox"/> <b>Simponi® (golimumab)</b> Inject 50 mg subq once a month	1 x 50 mg/0.5mL	<input type="checkbox"/> SmartJect® Autoinjector <input type="checkbox"/> PFS _____
<input type="checkbox"/> <b>Simponi Aria® (golimumab)</b> <input type="checkbox"/> Infuse _____ mg (2 mg/kg x _____ kg ) IV over 30 minutes at weeks 0 <input type="checkbox"/> Infuse _____ mg ( 2 mg/kg x _____ kg ) IV over 30 minutes at week 4 and every 8 weeks thereafter	_____ x 50 mg/4ml	Vials 0
	_____ x 50 mg/4ml	Vials _____
<input type="checkbox"/> <b>Stelara® (ustekinumab)</b> <input type="checkbox"/> Inject 45 mg subq on Day 1 (≤100 kg) <input type="checkbox"/> Inject 90 mg subq on Day 1 (>100 kg) <input type="checkbox"/> Inject 45 mg subq on Day 29 and every 12 weeks thereafter (≤100 kg) <input type="checkbox"/> Inject 90 mg subq on Day 29 and every 12 weeks thereafter (>100 kg)	<input type="checkbox"/> 1 x 45 mg/0.5mL <input type="checkbox"/> 1 x 90 mg/ mL	PFS 0
	<input type="checkbox"/> 1 x 45 mg/0.5mL <input type="checkbox"/> 1 x 90 mg/ mL	PFS _____
<input type="checkbox"/> <b>Taltz® (Ixekizumab)</b> <input type="checkbox"/> Inject 160 mg (2 x 80 mg) subq on week 0 <input type="checkbox"/> Inject 80 mg subq on week 4 and 4 weeks thereafter	2 x 80 mg/mL	<input type="checkbox"/> Autoinjectors <input type="checkbox"/> PFS 0
	1 x 80 mg/mL	<input type="checkbox"/> Autoinjector <input type="checkbox"/> PFS _____
<input type="checkbox"/> <b>Xeljanz® (tofacitinib)</b> <input type="checkbox"/> Take 5 mg by mouth twice daily <input type="checkbox"/> _____	60 x 5 mg tablets	_____
<input type="checkbox"/> <b>Xeljanz® XR (tofacitinib)</b> Take 11 mg by mouth once daily	30 x 11 mg tablets	_____

\*\* Refer to Forms Rheumatology A-E and Rheumatology F-Q for applicable medications \*\*

Injection Training Provided by:  Prescriber 's Office  Other: \_\_\_\_\_  
 CoxHealth at Home, skilled nursing visits to teach self administration of SQ injection and PRN

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

