RHEUMATOID ARTHRITIS SPECIALTY CARE PROGRAM

❶ PATIENT INFORMATION:

Name: _____
Address: _____
City: _____ State: ____ Zip: _____
Phone: _____ Alt. Phone: _____
Email: _____
DOB: _____ Gender: ❍ M ❍ F Caregiver: _____
Height: _____ Weight: _____ Allergies: _____

❷ PRESCRIBER INFORMATION:

Name: _____
Address: _____
City: _____ State: ____ Zip: _____
Phone: _____ Fax: _____
NPI: _____ DEA: _____
Tax I.D.: _____
Office Contact: _____ Phone: _____

❸ STATEMENT OF MEDICAL NECESSITY: (Please Attach All Medical Documentation)

Date of Diagnosis: _____
ICD-10: _____
Other: _____
TB Test: ❑ Positive ❑ Negative Date: _____

Patient also taking Methotrexate? ❑ Yes ❑ No
Serious or active infection present? ❑ Yes ❑ No
Hep B ruled out or treatment started? ❑ Yes ❑ No
Does patient have latex allergy? ❑ Yes ❑ No
LFT: ALT:_____ AST:_____ Date:_____

Prior Failed Treatments:

❑ Azulfidine® ❑ Celebrex® ❑ Methotrexate
❑ Biologics ❑ Corticosteroids ❑ Others
❑ Calcipotriene ❑ Indocin®

Indicate Drug Name and Length of Treatment:

_____
_____
_____

If Prior Authorization is denied, recommended formulary alternatives will be provided to the prescriber based upon the patient's insurance coverage.

❹ INJECTION TRAINING: ❍ Pharmacist to Provide Training ❍ Patient Trained in MD Office ❍ Manufacturer Nurse Support

❺ PRODUCT DELIVERY: ❍ Patient's Home ❍ Physician's Office ❍ Pharmacy to Coordinate

❻ INSURANCE INFORMATION: Please Include Front and Back Copies of Pharmacy and Medical Card

PRESCRIPTION INFORMATION: (Please be sure to choose both induction and maintenance dose where applicable)

Patient Name: _____ Patient's Date of Birth: _____

Medication	Dosage & Strength	Direction	QTY	Refills
❑ ACTEMRA®	❑ 162mg/0.9ml Prefilled Syringe ❑ 162mg/0.9ml Prefilled Autoinjector (ACTPen™)	❑ <220 lbs: Inject 162mg SC every other week, followed by an increase to every week based on clinical response ❑ ≥220 lbs: Inject 162mg SC every week		
❑ CIMZIA®	❑ Prefilled Syringe Starter Kit ❑ 200mg/ml Prefilled Syringe ❑ 200mg Lyophilized Powder Vial	❑ **Induction Dose:** Inject 400mg SC on day 1, day 14 and day 28	6	0
		❑ **Maintenance:** Inject 400mg SC every 4 weeks ❑ **Maintenance:** Inject 200mg SC every other week	2	
❑ COLCIGEL®	❑ _____	❑ _____		
❑ COSENTYX® (for PsA)	❑ 150mg/ml Sensoready® Pen ❑ 150mg/ml Prefilled Syringe ❑ 150mg/ml Lyophilized Powder Vial	❑ **Induction Dose:** Inject 150mg SC at weeks 0, 1, 2, 3, and 4	5	0
		❑ **Induction Dose:** Inject 300mg SC at weeks 0, 1, 2, 3, and 4	10	0
		❑ **Maintenance Dose:** Inject 150mg SC every four weeks	1	
		❑ **Maintenance Dose:** Inject 300mg SC every four weeks	2	
❑ ENBREL®	❑ 50mg/ml SureClick® Autoinjector ❑ 50mg/ml Enbrel Mini® Prefilled Cartridge *For Enbrel Mini® only: AutoTouch® Autoinjector* ❑ 50mg/ml Prefilled Syringe ❑ 25mg/0.5ml Prefilled Syringe ❑ 25mg/ml Vial	❑ Inject 50mg SC once a week		
❑ HUMIRA®	❑ 40mg/0.4ml Pen ❑ 40mg/0.4ml Prefilled Syringe ❑ 80mg/0.8ml Pen	❑ Inject 40mg SC every other week ❑ Inject 40mg SC once a week ❑ Inject 80mg SC every other week		
	All strengths and dosages listed are Humira® Citrate Free			
❑ KEVZARA®	❑ 150mg/1.14ml Prefilled Syringe ❑ 150mg/1.14ml Prefilled Pen ❑ 200mg/1.14ml Prefilled Syringe ❑ 200mg/1.14ml Prefilled Pen	❑ Inject 150mg SC every 2 weeks	2	
		❑ Inject 200mg SC every 2 weeks	2	
❑ OLUMIANT®	❑ 2mg Tablet ❑ 1mg Tablet	❑ Take one 2mg tablet by mouth with or without food daily	30	
		❑ Moderate Renal Impairment: Take one 1mg tablet by mouth with or without food daily	30	
❑ ORENCIA®	❑ 125mg/ml Prefilled Syringe ❑ 125mg/ml ClickJectTM Autoinjector ❑ 250mg Lyophilized Powder Vial	❑ **Induction Dose:** ❑ <60 kg: 500mg administered IV, then inject 125mg SC within 24 hours ❑ 60 to 100 kg: 750mg administered IV, then inject 125mg SC within 24 hours ❑ >100 kg: 1000mg administered IV, then inject 125mg SC within 24 hours		
		❑ Inject 125mg SC once a week		
❑ _____	_____	_____		

Otezla®, Rasuvo®, Rinvoq™, Simponi®, Stelara®, Taltz®, Tremfya™, Xeljanz®, and Xeljanz®XR are listed alphabetically on respective enrollment forms.

PRESCRIBER SIGNATURE:

I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs.

Signature: _____ Date: _____ Signature: _____ Date: _____

Substitution Permitted **Dispense As Written**

Prior authorization approval and insurance benefits will be determined by the payor based upon the patient's eligibility, medical necessity, and the terms of the patient's coverage, among other things. Participation in this program is not a guarantee of prior authorization or of payment.

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RHEUMATOID ARTHRITIS SPECIALTY CARE PROGRAM

KLOUDSCRIPT
Community Led Specialty Pharmacy Care

❶ PATIENT INFORMATION:

Name: _____
Address: _____
City: _____ State: ____ Zip: _____
Phone: _____ Alt. Phone: _____
Email: _____
DOB: _____ Gender: ❍ M ❍ F Caregiver: _____
Height: _____ Weight: _____ Allergies: _____

❷ PRESCRIBER INFORMATION:

Name: _____
Address: _____
City: _____ State: ____ Zip: _____
Phone: _____ Fax: _____
NPI: _____ DEA: _____
Tax I.D.: _____
Office Contact: _____ Phone: _____

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Hep B ruled out or treatment started? ❑ Yes ❑ No
Does patient have latex allergy? ❑ Yes ❑ No
LFT: ALT:_____ AST:_____ Date:_____

Prior Failed Treatments:

❑ Azulfidine® ❑ Celebrex® ❑ Methotrexate
❑ Biologics ❑ Corticosteroids ❑ Others
❑ Calcipotriene ❑ Indocin®

Indicate Drug Name and Length of Treatment:

_____
_____
_____

If Prior Authorization is denied, recommended formulary alternatives will be provided to the prescriber based upon the patient's insurance coverage.

❹ INJECTION TRAINING: ❍ Pharmacist to Provide Training ❍ Patient Trained in MD Office ❍ Manufacturer Nurse Support

❺ PRODUCT DELIVERY: ❍ Patient's Home ❍ Physician's Office ❍ Pharmacy to Coordinate

❻ INSURANCE INFORMATION: Please Include Front and Back Copies of Pharmacy and Medical Card

PRESCRIPTION INFORMATION: (Please be sure to choose both induction and maintenance dose where applicable)

Patient Name: _____ Patient's Date of Birth: _____

Medication	Dosage & Strength	Direction	QTY	Refills
❑ OTEZLA® (for PsA)	❑ Two-week Starter Pack (Titration) ❑ 28-day Starter Pack (Titration) ❑ 30mg tablets	❑ **Starter Pack:** Take one tablet in the morning on day 1, then take one tablet in the morning and one tablet in the evening as directed on the starter pack	1	0
		❑ **Maintenance:** Take one 30mg tablet by mouth twice daily **For patients with severe renal impairment take one 30mg tablet once daily and skip afternoon doses in Starter Pack*	60	
❑ RASUVO®	Single-dose auto-injector prefilled syringe: ❑ 7.5mg ❑ 10mg ❑ 12.5mg ❑ 15mg ❑ 17.5mg ❑ 20mg ❑ 22.5mg ❑ 25mg ❑ 30mg	❑ Inject 7.5 mg every week as directed		
❑ RINVOQ™	❑ 15mg Extended-Release Tablets	❑ Take one 15mg tablet once a day	30	
❑ SIMPONI®	❑ 50mg/0.5ml Smartject® Autoinjector ❑ 50mg/0.5ml Prefilled Syringe	❑ Inject 50mg SC once a month	1	
❑ STELARA® (for PsA)	❑ 45mg/0.5ml Prefilled Syringe ❑ 45mg/0.5ml Vial ❑ 90mg/1ml Prefilled Syringe	❑ **Induction Dose:** Inject 45mg SC on day 1	1	
		❑ **Maintenance:** Inject 45mg SC on day 29, and every 12 weeks thereafter	1	
		❑ **PsA with Coexistent Moderate-to-Severe Plaque Psoriasis (>220 lbs)** ❑ **Induction Dose:** Inject 90 SC on day 1	1	
		❑ **Maintenance:** Inject 90mg SC on day 29, and every 12 weeks thereafter	1	
	❑ Yes or ❑ No: ***STELARA SELF-INJECTION:*** *Healthcare provider certifies that patient has been trained and is eligible for self-injection*			
❑ TALTZ®	❑ 80mg/ml Single-Dose Prefilled Autoinjector ❑ 80mg/ml Single-Dose Prefilled Syringe	**Ankylosing Spondylitis**		
		❑ **Induction Dose:** Inject 160mg SC (two 80mg injections) at week 0	2	0
		❑ **Maintenance:** Inject 80mg SC every 4 weeks	1	
		Non-Radiographic Axial Spondyloarthritis		
		❑ Inject 80mg SC every 4 weeks	1	
		Psoriasis and Psoriatic Arthritis		
		❑ **Induction Dose:** Inject 160mg SC (two 80mg injections) at week 0	2	0
		❑ **Maintenance:** Inject 80mg SC every 4 weeks	1	
		❑ **PsA with Coexistent Moderate-to-Severe Plaque Psoriasis** ❑ **Weeks 0-2:** Inject 160mg SC (two 80mg injections) at week 0, then inject 80mg SC at week 2	3	0
		❑ **Weeks 4-10:** Inject 80mg SC at week 4 and every 2 weeks thereafter through week 10	2	1
		❑ **Weeks 12 and onwards:** Inject 80mg SC at week 12 and every 4 weeks thereafter	1	
❑ TREMFYA® (for PsA)	❑ 100mg/ml Prefilled Syringe ❑ 100mg/ml One-Press Patient Controlled Injector	❑ **Induction Dose:** Inject 100mg/ml SC at weeks 0 and 4	2	0
		❑ **Maintenance:** Inject 100mg/ml SC every 8 weeks thereafter	1	
❑ XELJANZ® ❑ XELJANZ® XR	❑ 5mg Tablet ❑ 11mg Tablet	❑ Take one 5mg tablet by mouth twice a day	60	
		❑ Take one 11mg tablet once a day **For patients with moderate renal or hepatic impairment take one 5mg tablet once daily*	30	
❑ _____	_____	_____		

Actemra®, Cimzia®, Colcigel®, Cosentyx®, Enbrel®, Humira®, Kevzara®, Olumiant® and Orencia® are listed alphabetically on respective enrollment forms.

PRESCRIBER SIGNATURE:

I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs.

Signature: _____ Date: _____ Signature: _____ Date: _____

Substitution Permitted **Dispense As Written**

Prior authorization approval and insurance benefits will be determined by the payor based upon the patient's eligibility, medical necessity, and the terms of the patient's coverage, among other things. Participation in this program is not a guarantee of prior authorization or of payment.

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