SMP PHARMACY SOLUTIONS

Fax#: 855-447-6637
Ph#: 855-650-5009

# Rheumatology (A-N) Prescription Faxable

**Today's Date:** _____ **Needed by:** _____ **Name:** _____ **Phone:** _____

**Patient Demographic:** (Provide the following or attached demographic sheet)
Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____ Alt. Phone: _____
SS#: _____ Date Birth: _____
Gender: _____ Height: _____ Weight _____ BSA _____ m2

**Prescriber:** (Provide as much information as possible)
Prescriber's Name: _____ Group/Hospital: _____
Specialty: _____ NPI #: _____ DEA: _____
Address: _____
City, State, Zip: _____
Phone: _____ Fax: _____
Alt. Contact Name: _____
Phone: _____ Position: _____

**Insurance Information** (Please copy and attach the front and back of the Insurance Card):
Primary Insurance Name: _____ ID# _____ BIN#: _____ Group#: _____ PCN#: _____ Phone: _____
☐ No Insurance ☐ Patient will pay out of pocket ☐ Enroll in Manufacturer's Patient Assistance Program

**Medication Delivery to** (Choose Only One):
☐ Patient Address ☐ First Fill Physician's Office, Refill to Patient Address ☐ Patient will pick up at Pharmacy

**Diagnosis (ICD-10 code):** ☐ M06.9 Rheumatoid Arthritis ☐ L40.54:L40.59 Psoriatic Arthritis ☐ M08.00 Polysrticular Juvenile Rheumatoid Arthritis ☐ M08.00 Systemic Juvenile Idiopathic Arthritis (SJIA) ☐ M45.9 Ankylosing Spondylitis ☐ M33.20 Polymyositis ☐ M81.0 Osteoporosis ☐ M32.10 Systemic Lupus Erythematosus

**Injection Training & Educational Needs:** ☐ Specialty Pharmacy Injection Training Requested ☐ Manufacturer's Patient Assistance Program Enrollment Requested **OR** (Please Choose only one) ☐ Physician's Office already trained Patient ☐ Patient is already independently Injecting

**Patient Allergies/ Allergic reactions:**
1. _____ 2. _____

**Prior (Failed) Medications** (Reason for D/C):
1. _____ 2. _____

| Medication | Dose/Strength | Direction | Qty. | Ref. |
|---|---|---|---|---|
| ☐ **Actemra®** | 162mg/0.9ml | ☐ Inject 162mg SC every other week<br>☐ Inject 162mg SC every week | | |
| ☐ **Cimzia®** | ☐ Cimzia Starter Kit (6 PF Syr.) | *Induction Dose*: Inject 400mg SC on day 1, at week 2, and at week 4. | | |
| | ☐ 200mg/1ml PF Syr.<br>☐ 200mg vial | *Maintenance Dose*: ☐ Inject 200mg SC every other week<br>☐ Inject 400mg SC every 4 weeks<br>Other: _____ | | |
| ☐ **Cosentyx®** | 150mg/ml | **Psoriatic Arthritis with Coexisting Moderate to Severe Plaque Psoriasis:** *With Loading Dose*: 300mg at weeks 0,1,2,3, and 4 every 4 weeks thereafter/*Maintenance Dose:* 300mg every 4 weeks | | |
| | | **Psoriatic Arthritis/Ankylosing Spondylitis**: *With Loading Dose*: 150mg at weeks 0,1,2,3, and 4 every 4 weeks thereafter / *Without Loading Dose*: 150mg every 4 weeks | | |
| ☐ **Enbrel®** | ☐ 25mg/0.5ml PF Syr.<br>☐ 25mg Vial<br>☐ 50mg/ml Sureclick™ Autoinjector<br>☐ 50mg/ml PF Syr. | ☐ Inject 25mg SC twice a week (72 to 96 hours apart)<br>☐ Inject 50mg SC once a week.<br>☐ Other: _____ | | |
| ☐ **Humira®** | ☐ 40 mg/ 0.8mL PFS<br>☐ 40 mg / 0.8 Pen | ☐ Inject 40mg SC every other week.<br>☐ Other: _____ | | |
| ☐ **Ilaris®** | ☐ 180mg Powdered Vial | ☐ **SJIA:** ☐ Inject 4mg/kg (with a max dose of 300mg) SC for body weight greater than or equal to 7.5kg every 4 weeks. | | |
| ☐ **Kevzara ®** | ☐ 150 mg / 1.14mL<br>☐ 200 mg / 1.14mL | ☐ Inject _____ mg every other week | | |

☐ Sharps Package: (Sterile sponges, alcohol swabs, sharps container)

By signing this form and utilizing our services, you are authorizing SMP and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies

_____ Prescriber Signature

_____/_____/_____ Date