SMP PHARMACY SOLUTIONS

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

Rheumatology (0-Z) 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 Juvenile Idiopathic Arthritis ☐ M45.9 Ankylosing Spondylitis ☐ M33.20 Polymyositis ☐ M81.0 Osteoporosis ☐ M32.10 Systemic Lupus Erythematosus ☐ Other

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.
☐ **Orencia®**	☐ 125mg PF Syr. ☐ ClickJect Autoinjector 125mg/ml, Pack of 4	☐ Inject 125mg SC once a week. ☐ *After Single IV Loading Dose*: Inject 125mg SC within a day, followed by 125mg SC injection every week thereafter. ☐ *Unable to Receive an IV Loading Dose*: Inject 125mg SC every week. ☐ *Patient Transitioning from IV Infusion Therapy*: Inject 125mg SC instead of the next schedule IV dose, followed by 125mg SC injections every week thereafter.		
	☐ 50 mg / 0.4mL PFS ☐ 87.5 mg / 0.7mL PFS	☐ Inject ___________ mg SC once a week		
☐ **Otelza®**	☐ Titration Starter Pack Rx	Day 1: 10mg orally in the morning. Day 2: 10mg orally in the morning and 10mg orally in the evening. Day 3: 10mg orally in the morning and 20mg orally in the evening. Day 4: 20mg orally in the morning and 20mg orally in the evening. Day 5: 20mg orally in the morning and 30mg orally in the evening. Day 6: and thereafter 30mg orally twice a day.		
	☐ 30mg	☐ *Maintenance Dose:* Take one capsule by mouth twice a day. ☐ Other: ______________________________		
☐ **Otrexup®**	10mg, 12.5mg, 15mg, 17.5mg, 20mg, 25mg,	☐ Inject ______________ mg SC once a week		
☐ ***Rasuvo®**	7.5mg 22.5 mg ,30mg (Only Rasuvo)			
☐ **Remicade®**	☐ 100mg/ml	☐ *Induction Dose*: Infuse _____mg/kg in 250ml of 0.9% NaCl at 0, 2 and 6 weeks. ☐ *Maintenance Dose*: Infuse _____mg/kg in 250ml of 0.9% NaCl every 6 weeks. ☐ *Maintenance Dose*: Infuse _____mg/kg in 250ml of 0.9% NaCl every 8 weeks. ☐ Other:_____________________________		
☐ **Simponi®**	☐ 50mg/0.5ml PFS ☐ 50mg / 0.5ml Pen	☐ Inject 50mg (0,5ml) SC once a month.		
☐ **Simponi ARIA™**	☐ 50mg/4ml Vial	☐ Infuse 2mg/kg in 0.9% NaCl over 30 minutes at weeks 0 and 4, then every 8 weeks thereafter.		
☐ **Stelara®**	☐ 45mg/0.5ml PF Syr. ☐ 90mg/ml PF Syr.	☐ **Patients less than 100kg weight (220 lbs.)**: Inject 45 SC initially and 4 weeks later, followed by 45mg every 12 weeks ☐ **Patient at or greater than 100kg weight (220 lbs.)**: Inject 90mg initially and 4 weeks later, followed by 90mg every 12 weeks.		
☐ **Xeljanz**	☐ 5mg	☐ Take one tablet orally twice a day.		
☐ **Xeljanz XR**	☐ 11mg	☐ Take one tablet orally once a day.		

☐ 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:______/________/________