SMP PHARMACY SOLUTIONS

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

Pediatric 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:_____
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): ☐ M08.0 Unspecified Juvenile RA ☐ M08.1 Juvenile Ankylosing Spondylitis ☐ M08.2 Juvenile RA with Systemic Onset
☐ M08.3 Juvenial Rheumatoid Polyarthritis (seronegative) ☐ M08.4 Pauciarticular Juvenile RA ☐ M08.8 Other Juvenile Arthritis
☐ M08.9 Juvenile Arthritis, Unspecified ☐ K50.00 Crohn's Disease of small intestine without complications
☐ K50.80 Crohn's Disease of small and large intestine without complications ☐ K50.90 Crohn's Disease, unspecified without complications

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.
☐ **Humira®**	☐ ρ0mg/0.ρml j#&ℚ	Juvenile Idiopathic Arthritis, moderate-severe: ☐ Patients ς ÙÏ ÁÎÄ ÏÌÄÅÒℍ 10 -14 ËÇℊ Inject 10mg S# every ς weekÓ.		
	☐ ς0mg/0.ς Í Ì j#&ℚ	☐ Patients ς ÙÏ ÁÎÄ ÏÌÄÅÒℍ 15 -29 ËÇℊ Inject 20mg S# every ς weekÓ.		
	☐ τ0mg/0.τ Í Ì j#&ℚ	☐ Patients ς ÙÏ ÁÎÄ ÏÌÄÅÒℍ €σπ ËÇℊ Inject τ0mg S# every ς weekÓ.		
	☐ Pediatric #ÒÏÈÎ's Disease Starter Package (CF) ☐ 20mg/0.2 Í Ì j#&ℚ	#ÒÏÈÎ's Diseaseℍ Í ÏÄeratezÓÅÖÅÒÅℊ ☐ 0ÁÔŒÅÎÔÓ φ ÙÏ ÁÎÄ ÏÌÄÅÒℍ 17-39 ËÇℊ Inject ψπmg S# ÏÎ ÄÁÙ ρℍ then 40mg on day 15, then 20mg every 2 weeks on day 29. ☐ Inject 2πmg S# every other week.		
	☐ Pediatric #ÒÏÈÎ's Disease Starter Package (CF) ☐ τ0mg/0.τ Í Ì j#&ℚ	☐ 0ÁÔŒÅÎÔÓ φ ÙÏ ÁÎÄ ÏÌÄÅÒ >40 ËÇℊ Inject 160mg S# ÏÎ ÄÁÙ ρℍ then 80 Í Ç on day 15, then 40mg every 2 weeks on day 29. ☐ Inject 4πmg S# every other week.		
☐ **Other**				

☐ 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's Signature

_____/_____/_____ Date