RHEUMATOID/PSORIATIC ARTHRITIS REFERRAL FORM (A-C)

PHONE 888.370.1724 | **FAX** 877.645.7514



PATIENT INFORMATION Last Name Address Email Primary Contact Method (check of primary Caregiver/Alt Contact Name of Contact Sending Referrance)	First Name	DOB		Gender	□M □F	Last 4 SSN		Primary Lar	nguage	
Address Email Primary Contact Method (check of Primary Caregiver/Alt Contact National PRESCRIBER INFORMATION (Check of Primary Caregiver/Alt Contact National Caregiver)		DOB		Gender	□M □F	Last 4 SSN		Drimary Lar	nguage	
Email Primary Contact Method (check of the primary Caregiver/Alt Contact National PRESCRIBER INFORMATION CONTACT NATIONAL PRESCRIBER INFORMATION CONTACT NATIONAL PRESCRIBER INFORMATION CONTACT NATIONAL PRESCRIBER INFORMATION CONTACT NATIONAL PROPERTY NATIONAL PRO	Home Phone	·						Filliary Lai	.94490	
Primary Contact Method (check of Primary Caregiver/Alt Contact Na PRESCRIBER INFORMATI	Home Phone		City				State		ZIP	
Primary Caregiver/Alt Contact Na PRESCRIBER INFORMATI		•	·	Wor	k Phone			Cell Pho	one	
PRESCRIBER INFORMATI	one) Cell Phone Home	e Phone 🗆 Work	Phone 🗆 Te	ext 🗆 Er	nail 🗆 Pri	imary Caregiver	□ DO NOT	CONTACT		
	me (If applicable)	Alt	Contact Emai	il				Alt Contact	Phone	
Name of Contact Sending Referra	ON									
	al	Title			Prefe	erred Contact Met	hod (check d	one) 🗆 Em	ail 🗆 Phone	□ Fax
Referral Contact Email		'		Office P	hone		Offi	ice Fax		
Practice / Facility Name				Prescrib	er Name / S	Specialty				
Address			C	City				State	ZIP	
Prescriber State License #	DEA#		N	NPI#			Medi	caid UPIN #		
	* Please inc	lude a copy c	of the froi	nt and l	back of	insurance ca	ard *			
CLINICAL INFORMATION										
Patient New to Therapy ☐ Naïve/	New Start □ Therapy Restar	t 🗆 Existing Treat	tment			The	erapy Start D	ate		
Sample/Starter Provided? ☐ No	☐ Yes, Provide Qty:	Date Provided:	Р	Patient Hei	ght (cm/in):	Weight	(kg/lbs):	Date	Obtained:	
If Self-injectable drug, is injection	training coordination required	l by our pharmacy?	Yes □ No	0	TB Skin Tes	st Result:	Re	esult Date:		
Other/Concomitant Medications ((please list)									
Allergies □ NKDA □ Drug Alle	ergies (please list)				Other Aller	gies (please list)				
Ship to Address ☐ Home ☐ P	rescriber's Office	lease list)								
□ L40.59	Arthropathic Psoriasis Other Psoriatic Arthropathy Rheumatoid arthritis, unspecifi	ed			venile rheur	juvenile rheumato natoid polyarthrit 		of unspecified	d site	
PRESCRIPTION INFORMA In order for a brand name pro or your state-specific required	duct to be dispensed, the p	orescriber must h	handwrite "E						:	
MEDICATION	DOSE		CTIONS	,	,				QTY	REFILLS
☐ Actemra* IV Administration Current Weight:kg	□ 80 mg Vial □ 200 mg Vial □ 400 mg Vial	□Ma				ce every 4 weeks once every 4 week	(S		4-week supply	
☐ Actemra® SubQ Administration Current Weight:kg	☐ 162 mg/0.9ml PFS ☐ 162 mg/0.9ml ACTPen Aut	<100	kg: ect 162 mg Su ect 162 mg Su			R week (increase based or	n clinical resu	ults)	2 4	
			ect 162 mg Su	ubQ once e	very week					
□ Bimzelx	☐ 160 mg/ml Autoinjector ☐ 160 mg/ml Syringe		Omg SC once :her:	every 4 we	eeks				1	
□ Cimzia* Note: Lyophilized poweder	Initial Dose: □ 200 mg/ml PFS □ 200 mg Lyophilized powde	Injec	tial Dose: ct 400 mg (2x	200 mg in	jections) Su	bQ at Weeks 0, 2	and 4		6	
vials should be prepared and administered by a health care professional.	Maintenance Dose: □ 200 mg/ml PFS □ 200 mg Lyophilized powde	□ Inj	tenance Dose ect 200 mg S ect 400 mg (2	ubQ every		ek SubQ every 4 wee	eks		4-week supply	
□ Cosentyx*	□ 75 mg/0.5 mL PFS □ 150 mg/ml PFS □ 150 mg/ml Sensoready Per	□ Inj n □ Inj	ect 150 mg Su	ubQ once v	veekly at W	eks 0, 1, 2, 3 and 4 eeks 0, 1, 2, 3 and SubQ once weekly	4	1, 2, 3 and 4	5 10	
		□ Inj □ Inj	itenance Dose ect 75 mg Sub ect 150 mg Su ect 300 mg (2	bQ once evubQ once e	every 4 wee		l weeks		4-week supply	

RHEUMATOID/PSORIATIC ARTHRITIS REFERRAL FORM (E-K)

PHONE 888.370.1724 | **FAX** 877.645.7514



Remove above por	tion before i	raxing	. Please com	ipiete ti	ne prescrip	tion for	rm ir	i its entire	ety and	i rax with s	ecure	e cove	er snee	et to the	e nur	nber ab	ove.	
PATIENT INFORMATION																		
Last Name	First N	ame		DOB			Gei	nder 🗆 M	□F	Last 4 SSN			F	Primary I	Langu	uage		
Address						City						State			Z	IP		
Email		Н	ome Phone					Work Pho	one					Cell F	Phone	•		
Primary Contact Method (check of	one) 🗆 Cell	Phone	☐ Home Ph	one [☐ Work Phon	ne 🗆 Te	ext	☐ Email	□ Pri	mary Caregiv	/er	□ DO	NOT	CONTAC	Т			
Primary Caregiver/Alt Contact Na	me (If applica	able)			Alt Cont	act Emai	il						/	Alt Conta	act Pl	hone		
PRESCRIBER INFORMATION	ON																	
Name of Contact Sending Referra	ıl			Т	itle				Prefe	rred Contact	t Meth	nod (ch	neck or	ne) 🗆 🗈	Email	☐ Phor	ne 🗆	Fax
Referral Contact Email							0	ffice Phone					Office	e Fax				
Practice / Facility Name							Pr	rescriber Na	ame / S	pecialty			!					
Address						(City							State			ZIP	
Prescriber State License #		DEA #	‡			1	NPI #	<u> </u>					Medica	aid UPIN	#			
	;	* Plea	ase includ	de a co	opv of th	ne froi	nt a	nd bac	k of i	nsurance	e ca	rd *						
CLINICAL INFORMATION																		
											The		D -					
Patient New to Therapy Naïve Naïve							7a+! -	nt Heimit 1	nn /! \	301			art Da		n+- ^	htalas -		
Sample/Starter Provided? No	· ·			Provide				nt Height (d			eight	(kg/lbs				btained:		
If Self-injectable drug, is injection		dinatio	n required by	our pha	irmacy? □ Y	es ⊔ No	0	TBS	KIN Tes	t Result:			Res	ult Date:				
Other/Concomitant Medications (-																	
Allergies NKDA Drug Alle			_					☐ Othe	r Allerg	jies (please l	ist)							
			Other (pleas	se list)														
□ L40.59	Arthropathic Other Psoriat Rheumatoid a	ic Arth	ropathy				□ MO			uvenile rheu natoid polyar 			ritis of	unspecif	fied si	ite		
PRESCRIPTION INFORMA																		
In order for a brand name pro or your state-specific required															ne			
MEDICATION	DOSE	ο ρι σι	non substitu	itions. I	DIRECTIO		anu	prescripti	on roi	TIT TOT WITCH	ig cc	inci On	eu me	dicatio	nis.	QTY		REFILLS
			i alatini Alaska inda	-4			h O h		- (70	20 1							-1-	REFILLS
☐ Enbrel® Adult Dosing	□ 50 mg/ml □ 50 mg/ml	PFS Mini C	lick™ Autoinje artridge upplies includ			_		wice a weer		96 hours apa	irt)					4-we supp		
	□ 25 mg /0.																	
☐ Enbrel* Pediatric Dosing Children ≥ 2 years old and adolescents Current Weight:kg	□ 50 mg/ml	al (inj sı I PFS	S upplies includ :lick™ Autoinje		>63 kg (13	.8 mg/kg 38 pound 0 mg Su	g/do: ds):	se SubQ on		eek (max dos	se: 50	mg/d	ose)			4-we supp		
☐ Humira* Citrate Free	□ 10 mg/0.1 □ 20 mg/0.2 □ 40 mg/0.4 □ 40 mg/0.6 □ 80 mg/0.8	2 mL P 4 mL P 4 mL P	FS FS en		☐ Inject 4 ☐ Inject 8 Polyarticu ☐ 10 kg (2 ☐ 15 kg (3	0/0.4 m 0/0.8 ml Ilar JIA: 22 lbs) to 33 lbs) to	L mg L mg c <15 c < 30	kg (66 lbs	y week y OTHE : Inject s): Injec	:	mL S	ubQ ev	ery O7	THER we		4-we supp		
□ Kevzara [*]	□ 200 mg/1 □ 200mg/1. □ 150 mg/1. □ 150mg/1.1	14ml A 14 ml P	utoinjector FS					every 2 wee every 2 we								4-we supp		
Prescriber Signature				ate			Supe	ervising Phy	vsician :	Signature (w	here ı	require	ed by st	tate law)	_	Date		_
Prescriber Signature DAW (Dispense as Written) Note: The information contained in this dot language, number of prescriptions allowed			Da al prescription. P	ate rescriber i		h his/her s	Bran	d Necessar	y (mus	t handwrite) Medical Board	guidelir	nes suct	as e-pr	escribing,	state s	pecific pres		

RHEUMATOID/PSORIATIC ARTHRITIS REFERRAL FORM (M-O)

PHONE 888.370.1724 | **FAX** 877.645.7514



Remove above portion before faxing. Please complete the prescription form in its entirety and fax with secure cover sheet to the number above.

·													
PATIENT INFORMATION													
Last Name	First Name	DOB			Gender	□ M □	F Last 4 S	SN		Primar	ry Langua	ige	
Address				City				9	State		ZIF	•	
Email	Home Pho	ne			Wo	rk Phone				Cel	II Phone		
Primary Contact Method (check of	one) 🗆 Cell Phone 🗆 Ho	me Phone	☐ Work Phone	= □ Te	ext 🗆 Eı	mail 🗆	Primary Care	giver		T CONTA	ACT		
Primary Caregiver/Alt Contact Na	me (If applicable)		Alt Conta	ct Emai	il					Alt Co	ntact Pho	one	
PRESCRIBER INFORMATION	ON												
Name of Contact Sending Referra		т	itle			Р	referred Cont	act Metho	od (check	one) [□ Email	☐ Phone	□ Fax
Referral Contact Email				-	Office F	Phone			Off	fice Fax			
Practice / Facility Name					Prescril	oer Name	e / Specialty						
Address		,			City					State	e	ZIP	
Prescriber State License #	DEA #	,		1	NPI#				Med	licaid UP	IN#		
	* Please in	clude a co	ony of the	e froi	nt and	back d	of insuran	ce car	d *				
CLINICAL INFORMATION					re arra i	ou ch c	or modram	cc car	<u> </u>				
				lotes				Thora	ny Ctart I	Data			
Patient New to Therapy Naïve		Date Provide		-	Dationt Hoi		/i>-		py Start I	Date	Date Ob		
Sample/Starter Provided? No [Patient Hei			Weight (k		It D		itained:	
If Self-injectable drug, is injection		ed by our pha	rmacy? 🗆 Ye	s ⊔ No	0	IB Skin	Test Result:		R	esult Da	te:		
Other/Concomitant Medications (
	rgies (please list)					Other A	llergies (pleas	se list)					
	rescriber's Office	(please list)											
□ L40.59	Arthropathic Psoriasis Other Psoriatic Arthropathy Rheumatoid arthritis, unspec						ied juvenile rh ieumatoid pol 		arthritis	of unspe	cified site	e	
PRESCRIPTION INFORMA In order for a brand name pro or your state-specific required	duct to be dispensed, th	e prescriber .	must handw	vrite "E							tions.		
MEDICATION	DOSE		DIRECTION	NS .								QTY	REFILLS
☐ Methotrexate*	☐ 2.5 mg tablet				tabl	ets) by m	nouth once we	eekly on t	he same o	day each	week	4-week supply	
	☐ 25 mg/mL (2 mL vial) In	j	Inject	mg S	Q once w	eekly on	the same day	each wee	ek			4-week supply	
□ Olumiant	☐ 1 mg tablet ☐ 2 mg tablet		□ Take 2 m □ Other: _		outh once	daily		_				30	
☐ Orencia [*] IV Administration	Orencia 250 mg Vial Adult:		Initial Dose		ma IV (ov	/er 30 mi	inutes) on Day	/ 1 Day 15	and Day	29		30	0
Current Weight:kg	□ <60 kg = 500 mg (2 Vial □ 60-100 kg = 750 mg (3 Vial □ >100 kg = 1,000 mg (4 Vial Pediatric: □ <75 kg = 10 mg/kg □ 75-100 kg = 750 mg (3 Vial □ >100 kg = 1,000 mg (4 Vial □ >100 kg = 1,000 mg (2 Vial □ >100 kg = 1,000 mg (2 Vial □ >100 kg = 1,000 mg (3 Vial □ >100 kg = 1,000 mg (4 Vial □ × × × × × × × × × × × × × × × × × × ×	/ials) 'ials) 'ials)	Maintenand	ce Dose):		es) every 4 w					4-week supply	
☐ Orencia [*] SubQ Administration Current Weight:kg	□ Orencia 125 mg/ml PFS □ Orencia 125 mg/ml Click □ Orencia 87.5 mg/0.7 ml l □ Orencia 50 mg/0.4 ml P	PFS	Adult Dose ☐ Inject 125 Pediatric D ☐ 10 to <25 ☐ >25 to <5 ☐ >50 kg: 1	5 mg St Pose: (> 5kg: 50 50kg: 8	2 years): mg SubQ 7.5 mg Sul	once wee	weekly					4-week supply	
Prescriber Signature		Date					ian Signature		quired by	ı state la	 	Date	
					Brand Noc	essary (r	must handwrit	(A)					

RHEUMATOID/PSORIATIC ARTHRITIS REFERRAL FORM (O-R)

PHONE 888.370.1724 | **FAX** 877.645.7514



Remove above portion before faxing. Please complete the prescription form in its entirety and fax with secure cover sheet to the number above.

·	_					-						
PATIENT INFORMATION												
Last Name	First Name	DOB			Gender	□M □F	Last 4 SSN		Pri	mary Langu	age	
Address				City				State		ZI	P	
Email	Home	Phone			Worl	c Phone				Cell Phone		
Primary Contact Method (check of	one) 🗆 Cell Phone 🏻	☐ Home Phone ☐	Work Phone	□Те	ext 🗆 Em	ail 🗆 Pr	imary Caregi	ver 🗆 DO	NOT CO	NTACT		
Primary Caregiver/Alt Contact Na	me (If applicable)		Alt Contac	ct Emai	il				Alt	: Contact Ph	ione	
PRESCRIBER INFORMATION	ON											
Name of Contact Sending Referra		Tit	tle			Pref	erred Contac	t Method (c	heck one	D □ Email	☐ Phone	□ Fax
Referral Contact Email	-				Office PI				Office F			
Practice / Facility Name					Prescrib	er Name /	Specialty					
Address				c	City				9	State	ZII	P
Prescriber State License #	DEA#				NPI#				Medicaid			
		e include a co	ny of the			ack of	insurance	e card *				
CLINICAL INFORMATION					it and b	ack or	msurance	cara				
CLINICAL INFORMATION				otes								
Patient New to Therapy ☐ Naïve/			-					Therapy S		5 . 0		
Sample/Starter Provided? ☐ No		Date Provided			Patient Heig			eight (kg/lb			btained:	
If Self-injectable drug, is injection	-	equired by our phar	macy? 🗆 Yes	s 🗆 No)	TB Skin Te	st Result:		Result	: Date:		
Other/Concomitant Medications (- '											
Allergies □ NKDA □ Drug Alle	ergies (please list)					Other Allei	rgies (please l	list)				
Ship to Address ☐ Home ☐ P	rescriber's Office 🗆 O	ther (please list)										
□ L40.59	Arthropathic Psoriasis Other Psoriatic Arthrop Rheumatoid arthritis, un						juvenile rheu matoid polya		ritis of un	specified si	te	
PRESCRIPTION INFORMA	<u>, </u>	•	hy state									
In order for a brand name pro	duct to be dispensed	l, the prescriber n	nust handw	rite "E								
or your state-specific required		t substitutions. Ti			alid presc	ription fo	orm for writi	ng control	led med	ications.		
MEDICATION	DOSE		DIRECTION	IS							QTY	REFILLS
□ Otezla*	Starter Pack (Titration (55 tablets)	on)		20 mg			ay 3: 10 mg A rting Day 6: Ta					
	☐ Maintance Rx 30 mg (Otezla tablets))	☐ Take one ☐ Other:		by mouth t	wice daily						
	☐ Bridge Rx 30 mg (Otezla tablets))	☐ Take one	tablet	by mouth t	wice daily						
□ Otrexup*	□ 12.5 mg/0.4 ml	⊒ 20 mg/0.4 ml ⊒ 22.5 mg/0.4 ml ⊒ 25 mg/0.4 ml	□ Inject	mg	g SQ once v	veekly on t	the same day	each week			4	
□ Rasuvo*	☐ 10 mg/0.2 ml ☐ 12.5 mg/0.25 ml ☐	□ 20 mg/0.4 ml □ 22.5 mg/0.45 ml □ 25 mg/0.5 ml □ 30 mg/0.6 ml	□ Inject	mg	g SQ once v	veekly on t	the same day	each week			4	
☐ Remicade* Current Weight:kg	□100 mg Vial		Initial Dose: Infuse 3 mg Infuse 5 mg	g/kg (g/kg (mg)	IV at Wee	ek 0, 2 and 6 (ek 0, 2 and 6 ((RA) (AS, PsA)				
			Maintenance Infuse 3 mg Infuse 10 m Infuse 10 m AS: Infuse 5 mg PsA: Infuse 5 mg Other:	g/kg (_ g/kg (_ g/kg (_ g/kg (_ g/kg (_	mg)mg)mg)mg)	IV every 4 IV every 8 IV every 6	weeks weeks weeks					
□Rinvoq	□ 15 mg		☐ Take one	15 mg 1	tablet by m	outh once	daily					
Prescriber Signature				-	Supervising	ı Physician	Signature (w	here requir	ed by stat	e law)	Date	
DAW (Dispense as Written)		 Date		-	Brand Nece	ssary (mu	st handwrite)					

RHEUMATOID/PSORIATIC ARTHRITIS REFERRAL FORM (S-T)

PHONE 888.370.1724 | **FAX** 877.645.7514



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PATIENT INFORMATION												
Last Name	First Name	DOB			Gender	□M □F	Last 4 SSN		Pri	mary Langu	ıage	
Address				City				State		z	IP	
Email	Home Phone	e			Wor	k Phone				Cell Phone	!	
Primary Contact Method (check of	one) 🗆 Cell Phone 🗆 Hom	ie Phone	Work Phone	e 🗆 Te	ext 🗆 En	nail 🗆 Pr	imary Caregiv	ver 🗆 DO	NOT CO	NTACT		
Primary Caregiver/Alt Contact Na	me (If applicable)		Alt Conta	ct Emai	il				Alt	Contact Pl	none	
PRESCRIBER INFORMATION	ON											
Name of Contact Sending Referra	l	Ti	tle			Pref	erred Contact	t Method (c	heck one) □ Email	☐ Phone	□ Fax
Referral Contact Email					Office P	hone		<u> </u>	Office I	-ax		
Practice / Facility Name					Prescrib	er Name /	Specialty					
Address				(City					State	ZIP)
Prescriber State License #	DEA#			N	NPI #				Medicaio	I UPIN #		
	* Please inc	lude a co	ον of the	e froi	nt and b	ack of	insurance	e card *				
CLINICAL INFORMATION												
Patient New to Therapy ☐ Naïve/								Therapy S	tart Dato			
Sample/Starter Provided? No I		Date Provide			Patient Heig	tht (cm/in)	. \\/	eight (kg/lb			btained:	
-								eigiit (kg/ib			btained.	
If Self-injectable drug, is injection		a by our pnar	macy? U Ye	s ⊔ No)	TB Skin Te	st Result:		Resun	Date:		
Other/Concomitant Medications (
	ergies (please list)					Other Allei	rgies (please l	ist)				
<u> </u>	rescriber's Office	olease list)										
	Arthropathic Psoriasis Other Psoriatic Arthropathy						juvenile rheu matoid polyai		ritis of ur	specified s	ite	
□ M06.9 F	Rheumatoid arthritis, unspecifi	ied			Other							
PRESCRIPTION INFORMA In order for a brand name pro					Brand Nec	essary" o	r "Brand Me	odically No	CASSARV			
or your state-specific required												
MEDICATION	DOSE		DIRECTION	NS S							QTY	REFILLS
□ Simponi*	☐ 50 mg/0.5 ml SmartJect*. ☐ 50 mg/0.5 ml PFS	Autoinjector	☐ Inject 50	mg Sub	oQ once a r	nonth					1 month supply	
□ Simponi Aria* Current Weight:kg	□ 50 mg/4 ml Vial		Adult Dosi				/eek 0 and W	eek 4				
			Adult Dosi				y 8 weeks					
			Pediatric Dosing (Children >2 years and Adolescents), Induction Dose: Infuse 2 mg/kg (mg) IV at Week 0 and Week 4									
			Pediatric Dosing (Children >2 years and Adolescents), Maintenance Dose: Infuse 2 mg/kg (mg) IV every 8 weeks									
			Other Dosi	ng:								
☐ Stelara Current Weight:kg	☐ 45 mg/0.5 ml PFS ☐ 90 mg/1 ml PFS		Induction I	mg Sul								
(recommended dose for coexistent PsA & PsO in			Maintenand									
patients>100kg = 90mg)			☐ Inject 45	mg Sul	bQ on day		ery 12 weeks ti ery 12 weeks t					
□ Taltz'	☐ 80 mg/ml PFS ☐ 80 mg/ml Pen		Induction I				t week 0					
							rthritis with c					
							weeks therea ery 4 weeks th		week 10			
			Maintenanc □ Inject 80				hritis/Psoriation	Arthritis w	coexistin /	g Psoriasis):	4 week supply	
□ Tremfya	☐ 100 mg/mL prefilled syring☐ 100 mg/mL one-press inje						t week 0 and Q once every		yringes/p	ens)		
Prescriber Signature		Date		-	Supervising	p Physician	Signature (w	here require	ed by stat	e law)	Date	
DAM (Diemones of Meithers)					Brand Nece	essary (mii	st handwrite)					
DAW (Dispense as Written)		Date				, , , ,u						

RHEUMATOID/PSORIATIC ARTHRITIS REFERRAL FORM (U-Z)

PHONE 888.370.1724 | **FAX** 877.645.7514



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PATIENT INFORMATION											
Last Name	First Name	е	DOB	C	Gender □ M	□F	Last 4 SSN		Primary Lar	nguage	
Address				City				State		ZIP	
Email		Home Phone			Work Pho	one			Cell Pho	one	
Primary Contact Method (check o	one) 🗆 Cell Pho	ne 🗆 Home Pho	ne 🗆 Work Phone	☐ Text	t 🗆 Email	□ Pr	imary Caregiver	□ DO NOT	CONTACT		
Primary Caregiver/Alt Contact Nar	me (If applicable)	Alt Contac	ct Email					Alt Contact	Phone	
PRESCRIBER INFORMATION	NC										
Name of Contact Sending Referral	ı		Title			Pref	erred Contact Me	thod (check o	one) 🗆 Em	ail 🗆 Phone	□ Fax
Referral Contact Email					Office Phone	,		Offi	ice Fax		
Practice / Facility Name					Prescriber Na	ame /	Specialty				
Address				Cit	у				State	ZIF	1
Prescriber State License #	DE	:A #		NP	I #			Medic	caid UPIN #		
	* P	lease include	a copy of the	front	and bac	k of	insurance c	ard *			
CLINICAL INFORMATION	- Please incl	ude applicable	clinical chart n	otes							
Patient New to Therapy ☐ Naïve/N				<u></u>			Th	erapy Start D	ate		
Sample/Starter Provided? ☐ No ☐			Provided:	Pat	ient Height (d	cm/in):		t (kg/lbs):		e Obtained:	
If Self-injectable drug, is injection	training coordin	ation required by o	ur pharmacy? 🗆 Ye	 s □ No	тв ѕ	kin Te	st Result:	Re	esult Date:		
Other/Concomitant Medications (· · ·									
Allergies □ NKDA □ Drug Alle)			□ Othe	r Aller	gies (please list)				
	escriber's Office		list)								
•	Arthropathic Pso				108.00 Unspe	cified	juvenile rheumat	oid arthritis o	of unspecified	d site	
□ L40.59 (Other Psoriatic A Rheumatoid arthr						matoid polyarthri				
PRESCRIPTION INFORMA			nuired by state								
In order for a brand name prod	duct to be disp	ensed, the presc	riber must handw	rite "Bra							
or your state-specific required		rohibit substituti			id prescripti	ion fo	rm for writing o	controlled m	nedications		
MEDICATION	DOSE		DIRECTION	IS						QTY	REFILLS
☐ Xatmep*	☐ 2.5 mg/ml or	al solution	□ Take		ne time weekl					1 month	
☐ Xeljanz*	☐ 5 mg tablet		☐ Take one	tablet by	mouth once	daily				60	
-			☐ Take one	tablet by		daily					
☐ Xeljanz*	☐ 5 mg tablet		☐ Take one	tablet by	mouth once	daily				60	
☐ Xeljanz*	☐ 5 mg tablet		☐ Take one	tablet by	mouth once	daily				60	
☐ Xeljanz*	☐ 5 mg tablet		☐ Take one	tablet by	mouth once	daily				60	
☐ Xeljanz*	☐ 5 mg tablet		☐ Take one	tablet by	mouth once	daily				60	
☐ Xeljanz*	☐ 5 mg tablet		☐ Take one	tablet by	mouth once	daily				60	
☐ Xeljanz*	☐ 5 mg tablet		☐ Take one	tablet by	mouth once	daily				60	
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☐ Xeljanz*	☐ 5 mg tablet		□ Take one	tablet by	mouth once	daily	Signature (where	e required by	state law)	60	