RHEUMATOID/PSORIATIC ARTHRITIS REFERRAL FORM (A-C)

PHONE 888.370.1724 | **FAX** 877.645.7514

AMBER SPECIALTY PHARMACY

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	Primary Language
Address		City	State	ZIP	
Email	Home Phone	Work Phone	Cell Phone		
Primary Contact Method (check one) ☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ Text ☐ Email ☐ Primary Caregiver ☐ DO NOT CONTACT					
Primary Caregiver/Alt Contact Name (If applicable)	Alt Contact Email	Alt Contact Phone			

PRESCRIBER INFORMATION

Name of Contact Sending Referral	Title	Preferred Contact Method (check one) ☐ Email ☐ Phone ☐ Fax		
Referral Contact Email	Office Phone	Office Fax		
Practice / Facility Name	Prescriber Name / Specialty			
Address	City	State	ZIP	
Prescriber State License #	DEA #	NPI #	Medicaid UPIN #	

** Please include a copy of the front and back of insurance card **

CLINICAL INFORMATION - Please include applicable clinical chart notes

Patient New to Therapy ☐ Naïve/New Start ☐ Therapy Restart ☐ Existing Treatment	Therapy Start Date		
Sample/Starter Provided? ☐ No ☐ Yes, Provide Qty: Date Provided:	Patient Height (cm/in):	Weight (kg/lbs):	Date Obtained:
If Self-injectable drug, is injection training coordination required by our pharmacy? ☐ Yes ☐ No	TB Skin Test Result:	Result Date:	
Other/Concomitant Medications (please list)			
Allergies ☐ NKDA ☐ Drug Allergies (please list) ☐ Other Allergies (please list)			
Ship to Address ☐ Home ☐ Prescriber's Office ☐ Other (please list)			

ICD-10 Code

☐ L40.50 Arthropathic Psoriasis
☐ L40.59 Other Psoriatic Arthropathy
☐ M06.9 Rheumatoid arthritis, unspecified
☐ M08.00 Unspecified juvenile rheumatoid arthritis of unspecified site
☐ M08.3 Juvenile rheumatoid polyarthritis
☐ Other _____

PRESCRIPTION INFORMATION - Please Escribe if required by state law

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary," or your state-specific required language to prohibit substitutions. This form is not a valid prescription form for writing controlled medications.

MEDICATION	DOSE	DIRECTIONS	QTY	REFILLS
☐ Actemra® IV Administration Current Weight: _____kg	☐ 80 mg Vial ☐ 200 mg Vial ☐ 400 mg Vial	☐ Induction dose: Infuse 4 mg/kg IV once every 4 weeks ☐ Maintenance Dose: Infuse 8mg/kg IV once every 4 weeks ☐ Other: _____	4-week supply	
☐ Actemra® SubQ Administration Current Weight: _____kg	☐ 162 mg/0.9ml PFS ☐ 162 mg/0.9ml ACTPen Autoinjector	<100 kg: ☐ Inject 162 mg SubQ once every OTHER week ☐ Inject 162 mg SubQ once every week (increase based on clinical results) >100 kg: ☐ Inject 162 mg SubQ once every week	2 4	
☐ Bimzelx	☐ 160 mg/ml Autoinjector ☐ 160 mg/ml Syringe	☐ 160mg SC once every 4 weeks ☐ Other: _____	1	
☐ Cimzia® *Note: Lyophilized poweder vials should be prepared and administered by a health care professional.*	Initial Dose: ☐ 200 mg/ml PFS ☐ 200 mg Lyophilized powder vial	☐ Initial Dose: Inject 400 mg (2x200 mg injections) SubQ at Weeks 0, 2 and 4	6	
	Maintenance Dose: ☐ 200 mg/ml PFS ☐ 200 mg Lyophilized powder vial	Maintenance Dose: ☐ Inject 200 mg SubQ every OTHER week ☐ Inject 400 mg (2x200 mg injections) SubQ every 4 weeks	4-week supply	
☐ Cosentyx®	☐ 75 mg/0.5 mL PFS ☐ 150 mg/ml PFS ☐ 150 mg/ml Sensoready Pen	Loading Dose: ☐ Inject 75 mg SubQ once weekly at Weeks 0, 1, 2, 3 and 4 ☐ Inject 150 mg SubQ once weekly at Weeks 0, 1, 2, 3 and 4 ☐ Inject 300 mg (2x150 mg injections) SubQ once weekly at Weeks 0, 1, 2, 3 and 4	5 10	
		Maintenance Dose: ☐ Inject 75 mg SubQ once every 4 weeks ☐ Inject 150 mg SubQ once every 4 weeks ☐ Inject 300 mg (2x150 mg injections) SubQ once every 4 weeks	4-week supply	

Prescriber Signature _____ Date _____

Supervising Physician Signature (where required by state law) _____ Date _____

DAW (Dispense as Written) _____ Date _____

Brand Necessary (must handwrite) _____

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REV010824

RHEUMATOID/PSORIATIC ARTHRITIS REFERRAL FORM (E-K)

PHONE 888.370.1724 | **FAX** 877.645.7514

AMBER SPECIALTY PHARMACY

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PATIENT INFORMATION

Last Name	First Name	DOB	Gender ☐ M ☐ F	Last 4 SSN	Primary Language
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Email	Home Phone	Work Phone	Cell Phone		
Primary Contact Method (check one) ☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ Text ☐ Email ☐ Primary Caregiver ☐ DO NOT CONTACT					
Primary Caregiver/Alt Contact Name (If applicable)	Alt Contact Email	Alt Contact Phone			

PRESCRIBER INFORMATION

Name of Contact Sending Referral	Title	Preferred Contact Method (check one) ☐ Email ☐ Phone ☐ Fax		
Referral Contact Email	Office Phone	Office Fax		
Practice / Facility Name	Prescriber Name / Specialty			
Address	City	State	ZIP	
Prescriber State License #	DEA #	NPI #	Medicaid UPIN #	

** Please include a copy of the front and back of insurance card **

CLINICAL INFORMATION - Please include applicable clinical chart notes

Patient New to Therapy ☐ Naïve/New Start ☐ Therapy Restart ☐ Existing Treatment		Therapy Start Date	
Sample/Starter Provided? ☐ No ☐ Yes, Provide Qty: Date Provided:	Patient Height (cm/in):	Weight (kg/lbs):	Date Obtained:
If Self-injectable drug, is injection training coordination required by our pharmacy? ☐ Yes ☐ No	TB Skin Test Result:	Result Date:	
Other/Concomitant Medications (please list)			
Allergies ☐ NKDA ☐ Drug Allergies (please list)	☐ Other Allergies (please list)		
Ship to Address ☐ Home ☐ Prescriber's Office ☐ Other (please list)			

ICD-10 Code

☐ L40.50 Arthropathic Psoriasis
☐ L40.59 Other Psoriatic Arthropathy
☐ M06.9 Rheumatoid arthritis, unspecified
☐ M08.00 Unspecified juvenile rheumatoid arthritis of unspecified site
☐ M08.3 Juvenile rheumatoid polyarthritis
☐ Other _____

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MEDICATION	DOSE	DIRECTIONS	QTY	REFILLS
☐ Enbrel® Adult Dosing	☐ 50 mg/ml Sureclick™ Autoinjector ☐ 50 mg/ml PFS ☐ 50 mg/ml Mini Cartridge ☐ 25 mg Vial (inj supplies included) ☐ 25 mg /0.5 ml PFS	☐ Inject 25 mg SubQ twice a week (72 - 96 hours apart) ☐ Other: _____	4-week supply	
☐ Enbrel® Pediatric Dosing Children ≥ 2 years old and adolescents Current Weight: _____kg	☐ 25 mg/0.5 ml PFS ☐ 25 mg Vial (inj supplies included) ☐ 50 mg/ml PFS ☐ 50 mg /ml Sureclick™ Autoinjector	<63 kg (138 pounds): ☐ Inject 0.8 mg/kg/dose SubQ once a week (max dose: 50 mg/dose) >63 kg (138 pounds): ☐ Inject 50 mg SubQ once a week ☐ Other: _____	4-week supply	
☐ Humira® Citrate Free	☐ 10 mg/0.1 mL PFS ☐ 20 mg/0.2 mL PFS ☐ 40 mg/0.4 mL PFS ☐ 40 mg/0.4 mL Pen ☐ 80 mg/0.8 mL Pen	☐ Inject 40/0.4 mL mg SubQ every OTHER week ☐ Inject 40/0.4 mL mg SubQ every week ☐ Inject 80/0.8 mL mg SubQ every OTHER week Polyarticular JIA: ☐ 10 kg (22 lbs) to <15 kg (33 lbs): Inject 10 mg/0.1 mL SubQ every OTHER week ☐ 15 kg (33 lbs) to < 30 kg (66 lbs): Inject 20 mg/0.2 mL SubQ every OTHER week ☐ Weight >30 kg (66 lbs): Inject 40 mg/0.4 mL SubQ every OTHER week	4-week supply	
☐ Kevzara®	☐ 200 mg/1.14 ml PFS ☐ 200mg/1.14ml Autoinjector ☐ 150 mg/1.14 ml PFS ☐ 150mg/1.14ml Autoinjector	☐ Inject 150 mg SubQ every 2 weeks ☐ Inject 200 mg SubQ every 2 weeks	4-week supply	

Prescriber Signature _____ Date _____

Supervising Physician Signature (where required by state law) _____ Date _____

DAW (Dispense as Written) _____ Date _____

Brand Necessary (must handwrite) _____

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REV010824

RHEUMATOID/PSORIATIC ARTHRITIS REFERRAL FORM (M-O)

PHONE 888.370.1724 | **FAX** 877.645.7514

AMBER SPECIALTY PHARMACY

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PATIENT INFORMATION

Last Name	First Name	DOB	Gender ☐ M ☐ F	Last 4 SSN	Primary Language
Address		City	State	ZIP	
Email	Home Phone	Work Phone	Cell Phone		
Primary Contact Method (check one) ☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ Text ☐ Email ☐ Primary Caregiver ☐ DO NOT CONTACT					
Primary Caregiver/Alt Contact Name (If applicable)	Alt Contact Email	Alt Contact Phone			

PRESCRIBER INFORMATION

Name of Contact Sending Referral	Title	Preferred Contact Method (check one) ☐ Email ☐ Phone ☐ Fax		
Referral Contact Email	Office Phone	Office Fax		
Practice / Facility Name	Prescriber Name / Specialty			
Address	City	State	ZIP	
Prescriber State License #	DEA #	NPI #	Medicaid UPIN #	

** Please include a copy of the front and back of insurance card **

CLINICAL INFORMATION - Please include applicable clinical chart notes

Patient New to Therapy ☐ Naïve/New Start ☐ Therapy Restart ☐ Existing Treatment		Therapy Start Date	
Sample/Starter Provided? ☐ No ☐ Yes, Provide Qty: Date Provided:	Patient Height (cm/in):	Weight (kg/lbs):	Date Obtained:
If Self-injectable drug, is injection training coordination required by our pharmacy? ☐ Yes ☐ No	TB Skin Test Result:	Result Date:	
Other/Concomitant Medications (please list)			
Allergies ☐ NKDA ☐ Drug Allergies (please list)	☐ Other Allergies (please list)		
Ship to Address ☐ Home ☐ Prescriber's Office ☐ Other (please list)			

ICD-10 Code

☐ L40.50 Arthropathic Psoriasis
☐ L40.59 Other Psoriatic Arthropathy
☐ M06.9 Rheumatoid arthritis, unspecified
☐ M08.00 Unspecified juvenile rheumatoid arthritis of unspecified site
☐ M08.3 Juvenile rheumatoid polyarthritis
☐ Other _____

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MEDICATION	DOSE	DIRECTIONS	QTY	REFILLS
☐ Methotrexate*	☐ 2.5 mg tablet	Take _____mg (_____tablets) by mouth once weekly on the same day each week	4-week supply	
	☐ 25 mg/mL (2 mL vial) Inj	Inject _____mg SQ once weekly on the same day each week	4-week supply	
☐ Olumiant	☐ 1 mg tablet ☐ 2 mg tablet	☐ Take 2 mg by mouth once daily ☐ Other: _____	30	
☐ Orencia* *IV Administration* Current Weight: _____kg	Orencia 250 mg Vial Adult: ☐ <60 kg = 500 mg (2 Vials) ☐ 60-100 kg = 750 mg (3 Vials) ☐ >100 kg = 1,000 mg (4 Vials) Pediatric: ☐ <75 kg = 10 mg/kg ☐ 75-100 kg = 750 mg (3 Vials) ☐ >100 kg = 1,000 mg (4 Vials)	Initial Dose: ☐ Infuse _____ mg IV (over 30 minutes) on Day 1, Day 15 and Day 29 Maintenance Dose: Infuse _____mg IV (over 30minutes) every 4 weeks	30 4-week supply	0
☐ Orencia* *SubQ Administration* Current Weight: _____kg	☐ Orencia 125 mg/ml PFS ☐ Orencia 125 mg/ml ClickJect™ ☐ Orencia 87.5 mg/0.7 ml PFS ☐ Orencia 50 mg/0.4 ml PFS	Adult Dose: ☐ Inject 125 mg SubQ once weekly Pediatric Dose: (>2 years): ☐ 10 to <25kg: 50 mg SubQ once weekly ☐ >25 to <50kg: 87.5 mg SubQ once weekly ☐ >50 kg: 125 mg SubQ once weekly	4-week supply	

Prescriber Signature _____ Date _____

Supervising Physician Signature (where required by state law) _____ Date _____

DAW (Dispense as Written) _____ Date _____

Brand Necessary (must handwrite) _____

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REV010824

RHEUMATOID/PSORIATIC ARTHRITIS REFERRAL FORM (O-R)

PHONE 888.370.1724 | **FAX** 877.645.7514

AMBER SPECIALTY PHARMACY

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PATIENT INFORMATION

Last Name	First Name	DOB	Gender ☐ M ☐ F	Last 4 SSN	Primary Language
Address		City	State	ZIP	
Email	Home Phone	Work Phone	Cell Phone		
Primary Contact Method (check one) ☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ Text ☐ Email ☐ Primary Caregiver ☐ DO NOT CONTACT					
Primary Caregiver/Alt Contact Name (If applicable)	Alt Contact Email	Alt Contact Phone			

PRESCRIBER INFORMATION

Name of Contact Sending Referral	Title	Preferred Contact Method (check one) ☐ Email ☐ Phone ☐ Fax		
Referral Contact Email	Office Phone	Office Fax		
Practice / Facility Name	Prescriber Name / Specialty			
Address	City	State	ZIP	
Prescriber State License #	DEA #	NPI #	Medicaid UPIN #	

** Please include a copy of the front and back of insurance card **

CLINICAL INFORMATION - Please include applicable clinical chart notes

Patient New to Therapy ☐ Naïve/New Start ☐ Therapy Restart ☐ Existing Treatment		Therapy Start Date	
Sample/Starter Provided? ☐ No ☐ Yes, Provide Qty: Date Provided:	Patient Height (cm/in):	Weight (kg/lbs):	Date Obtained:
If Self-injectable drug, is injection training coordination required by our pharmacy? ☐ Yes ☐ No	TB Skin Test Result:	Result Date:	
Other/Concomitant Medications (please list)			
Allergies ☐ NKDA ☐ Drug Allergies (please list)	☐ Other Allergies (please list)		
Ship to Address ☐ Home ☐ Prescriber's Office ☐ Other (please list)			

ICD-10 Code

☐ L40.50 Arthropathic Psoriasis
☐ L40.59 Other Psoriatic Arthropathy
☐ M06.9 Rheumatoid arthritis, unspecified
☐ M08.00 Unspecified juvenile rheumatoid arthritis of unspecified site
☐ M08.3 Juvenile rheumatoid polyarthritis
☐ Other _____

PRESCRIPTION INFORMATION - Please Escribe if required by state law

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MEDICATION	DOSE	DIRECTIONS	QTY	REFILLS
☐ Otezla®	☐ Starter Pack (Titration) (55 tablets)	☐ Day 1: 10 mg AM; Day 2: 10 mg BID; Day 3: 10 mg AM and 20 mg PM; Day 4: 20 mg BID; Day 5: 20 mg AM & 30 mg PM. Starting Day 6: Take one 30 mg tablet by mouth twice daily.		
	☐ Maintance Rx 30 mg (Otezla tablets)	☐ Take one tablet by mouth twice daily ☐ Other: _____		
	☐ Bridge Rx 30 mg (Otezla tablets)	☐ Take one tablet by mouth twice daily		
☐ Otrexup®	☐ 10 mg/0.4 ml ☐ 12.5 mg/0.4 ml ☐ 15 mg/0.4 ml ☐ 17.5 mg/0.4 ml ☐ 20 mg/0.4 ml ☐ 22.5 mg/0.4 ml ☐ 25 mg/0.4 ml	☐ Inject _____mg SQ once weekly on the same day each week	4	
☐ Rasuvo®	☐ 7.5 mg/0.15 ml ☐ 10 mg/0.2 ml ☐ 12.5 mg/0.25 ml ☐ 15 mg/0.3 ml ☐ 17.5 mg/0.35 ml ☐ 20 mg/0.4 ml ☐ 22.5 mg/0.45 ml ☐ 25 mg/0.5 ml ☐ 30 mg/0.6 ml	☐ Inject _____mg SQ once weekly on the same day each week	4	
☐ Remicade® Current Weight: _____kg	☐ 100 mg Vial	Initial Dose: Infuse 3 mg/kg (_____ mg) IV at Week 0, 2 and 6 (RA) Infuse 5 mg/kg (_____ mg) IV at Week 0, 2 and 6 (AS, PsA) ☐ Other: _____		
		Maintenance Dose: Infuse 3 mg/kg (_____ mg) IV every 8 weeks Infuse 10 mg/kg (_____mg) IV every 4 weeks Infuse 10 mg/kg (_____mg) IV every 8 weeks AS: Infuse 5 mg/kg (_____ mg) IV every 6 weeks PsA: Infuse 5 mg/kg (_____ mg) IV every 8 weeks ☐ Other: _____		
☐ Rinvoq	☐ 15 mg	☐ Take one 15 mg tablet by mouth once daily		

Prescriber Signature _____ Date _____

Supervising Physician Signature (where required by state law) _____ Date _____

DAW (Dispense as Written) _____ Date _____

Brand Necessary (must handwrite) _____

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REV010824

RHEUMATOID/PSORIATIC ARTHRITIS REFERRAL FORM (S-T)

PHONE 888.370.1724 | **FAX** 877.645.7514

AMBER SPECIALTY PHARMACY

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PATIENT INFORMATION

Last Name	First Name	DOB	Gender ☐ M ☐ F	Last 4 SSN	Primary Language
Address		City	State	ZIP	
Email	Home Phone	Work Phone	Cell Phone		
Primary Contact Method (check one) ☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ Text ☐ Email ☐ Primary Caregiver ☐ DO NOT CONTACT					
Primary Caregiver/Alt Contact Name (If applicable)	Alt Contact Email	Alt Contact Phone			

PRESCRIBER INFORMATION

Name of Contact Sending Referral	Title	Preferred Contact Method (check one) ☐ Email ☐ Phone ☐ Fax		
Referral Contact Email	Office Phone	Office Fax		
Practice / Facility Name	Prescriber Name / Specialty			
Address	City	State	ZIP	
Prescriber State License #	DEA #	NPI #	Medicaid UPIN #	

** Please include a copy of the front and back of insurance card **

CLINICAL INFORMATION - Please include applicable clinical chart notes

Patient New to Therapy ☐ Naïve/New Start ☐ Therapy Restart ☐ Existing Treatment			Therapy Start Date
Sample/Starter Provided? ☐ No ☐ Yes, Provide Qty: Date Provided:	Patient Height (cm/in):	Weight (kg/lbs):	Date Obtained:
If Self-injectable drug, is injection training coordination required by our pharmacy? ☐ Yes ☐ No	TB Skin Test Result:	Result Date:	
Other/Concomitant Medications (please list)			
Allergies ☐ NKDA ☐ Drug Allergies (please list)	☐ Other Allergies (please list)		
Ship to Address ☐ Home ☐ Prescriber's Office ☐ Other (please list)			

ICD-10 Code

☐ L40.50 Arthropathic Psoriasis
☐ L40.59 Other Psoriatic Arthropathy
☐ M06.9 Rheumatoid arthritis, unspecified
☐ M08.00 Unspecified juvenile rheumatoid arthritis of unspecified site
☐ M08.3 Juvenile rheumatoid polyarthritis
☐ Other _____

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MEDICATION	DOSE	DIRECTIONS	QTY	REFILLS
☐ Simponi®	☐ 50 mg/0.5 ml SmartJect® Autoinjector ☐ 50 mg/0.5 ml PFS	☐ Inject 50mg SubQ once a month	1 month supply	
☐ Simponi Aria® Current Weight: _____kg	☐ 50 mg/4 ml Vial	Adult Dosing, Induction Dose: Infuse 2 mg/kg (_____ mg) IV at Week 0 and Week 4		
		Adult Dosing, Maintenance Dose: Infuse 2 mg/kg (_____ mg) IV every 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 Dosing: _____		
☐ Stelara Current Weight: _____kg *(recommended dose for coexistent PsA & PsO in patients>100kg = 90mg)*	☐ 45 mg/0.5 ml PFS ☐ 90 mg/1 ml PFS	Induction Dose: ☐ Inject 45 mg SubQ on day 1 ☐ Inject 90 mg SubQ on day 1		
		Maintenance Dose: ☐ Inject 45 mg SubQ on day 29 and every 12 weeks thereafter ☐ Inject 90 mg SubQ on day 29 and every 12 weeks thereafter		
☐ Taltz®	☐ 80 mg/ml PFS ☐ 80 mg/ml Pen	Induction Dose (Psoriatic Arthritis): ☐ Inject 160mg (2x80mg) SubQ once at week 0		
		Induction Dose (Psoriasis or Psoriatic Arthritis with coexisting Psoriasis): ☐ Inject 160mg (2x80mg) SubQ at week 0, followed by 80mg SubQ at week 2 ☐ Inject 80mg SubQ at week 4 and every 2 weeks thereafter through week 10 ☐ Inject 80mg SubQ at week 12 and every 4 weeks thereafter		
		Maintenance Dose (Psoriasis/Psoriatic Arthritis/Psoriatic Arthritis w/ coexisting Psoriasis): ☐ Inject 80mg SubQ every 4 weeks	4 week supply	
☐ Tremfya	☐ 100 mg/mL prefilled syringe ☐ 100 mg/mL one-press injector	☐ Induction Dose: inject 100mg SubQ at week 0 and week 4 (2 syringes/pens) ☐ Maintenance Dose: Inject 100mg SubQ once every 8 weeks		

Prescriber Signature _____ Date _____

Supervising Physician Signature (where required by state law) _____ Date _____

DAW (Dispense as Written) _____ Date _____

Brand Necessary (must handwrite) _____

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REV010824

RHEUMATOID/PSORIATIC ARTHRITIS REFERRAL FORM (U-Z)

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AMBER SPECIALTY PHARMACY

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Email	Home Phone		Work Phone		Cell Phone
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Primary Caregiver/Alt Contact Name (If applicable)		Alt Contact Email			Alt Contact Phone

PRESCRIBER INFORMATION

Name of Contact Sending Referral	Title	Preferred Contact Method (check one) ☐ Email ☐ Phone ☐ Fax		
Referral Contact Email		Office Phone	Office Fax	
Practice / Facility Name		Prescriber Name / Specialty		
Address		City	State	ZIP
Prescriber State License #	DEA #	NPI #	Medicaid UPIN #	

** Please include a copy of the front and back of insurance card **

CLINICAL INFORMATION - Please include applicable clinical chart notes

Patient New to Therapy ☐ Naïve/New Start ☐ Therapy Restart ☐ Existing Treatment			Therapy Start Date	
Sample/Starter Provided? ☐ No ☐ Yes, Provide Qty: Date Provided:		Patient Height (cm/in):	Weight (kg/lbs):	Date Obtained:
If Self-injectable drug, is injection training coordination required by our pharmacy? ☐ Yes ☐ No		TB Skin Test Result:	Result Date:	
Other/Concomitant Medications (please list)				
Allergies ☐ NKDA ☐ Drug Allergies (please list)		☐ Other Allergies (please list)		
Ship to Address ☐ Home ☐ Prescriber's Office ☐ Other (please list)				

ICD-10 Code

☐ L40.50 Arthropathic Psoriasis
☐ L40.59 Other Psoriatic Arthropathy
☐ M06.9 Rheumatoid arthritis, unspecified
☐ M08.00 Unspecified juvenile rheumatoid arthritis of unspecified site
☐ M08.3 Juvenile rheumatoid polyarthritis
☐ Other _____

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In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary," or your state-specific required language to prohibit substitutions. This form is not a valid prescription form for writing controlled medications.

MEDICATION	DOSE	DIRECTIONS	QTY	REFILLS
☐ Xatmep®	☐ 2.5 mg/ml oral solution	☐ Take _____mg one time weekly	1 month	
☐ Xeljanz®	☐ 5 mg tablet	☐ Take one tablet by mouth once daily	60	
☐ Xeljanz XR®	☐ 11 mg XR tablet	☐ Take one tablet by mouth once daily	30	

Prescriber Signature _____ Date _____ Supervising Physician Signature (where required by state law) _____ Date _____

DAW (Dispense as Written) _____ Date _____ Brand Necessary (must handwrite) _____

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REV.010824