

Deliver to: Patient's Home Prescriber's Office Other: _____ Hold shipment until notified by prescriber Anticipated Start Date: _____

1. Patient Information

Last Name: _____ Home Phone: _____ Work/Mobile Phone: _____
 First Name: _____ Home Address: _____
 S.S. #: _____ Date of Birth: _____ City: _____ State: _____ Zip: _____
 Guardian/Caregiver: _____ Sex: Male Female Height: _____ Weight: _____ lbs. kg.

2. Patient Insurance Information (Please fax front and back copy of all insurance cards - prescription & medical)

Medical Insurance: _____ Phone: _____ Prescription Card: _____ Phone: _____
 Subscriber Name: _____ Policy #: _____ BIN/PCN: _____
 Policy #: _____ Group #: _____ Medicare #: _____ Medicaid #: _____

3. Prescriber Information

Prescriber Name: _____ MD DO NP PA License #: _____ NPI #: _____ DEA #: _____
 Practice Name: _____ Phone: _____ Fax: _____
 Address: _____ Office Contact: _____ Phone: _____
 City: _____ State: _____ Zip: _____ Collaborating Physician: _____

4. Diagnosis & Clinical Information (Please fax recent clinical notes, labs and tests, with the prescription to expedite the prior authorization)

Primary ICD-10: _____ Meds Tried & Failed: _____
 Secondary ICD-10: _____ Concurrent Medications: _____
 Allergies: _____ DMARDS: _____ NSAIDs: _____
 Vaccination History: _____ Biologics: _____ Other: _____

5. Prescription Information (Actemra, Benlysta, Cimzia, Cosentyx, Enbrel, and Humira are available on the Rheumatology Referral Form A-H)

Medication	Dose/Strength	Directions	Dispense	Refills
ILARIS®	<input type="checkbox"/> 150 mg LYO <input type="checkbox"/> 150 mg/mL solution	• ≥ 7.5 kg (16.5 lbs): Inject 4 mg/kg (maximum of 300 mg) SC every 4 weeks		
KEVZARA®	<input type="checkbox"/> 200 mg/1.14 mL PFS <input type="checkbox"/> 150 mg/1.14 mL PFS	<input type="checkbox"/> Inject 200 mg SC once every two weeks <input type="checkbox"/> Inject 150 mg SC once every two weeks		
OLUMIANT®	<input type="checkbox"/> 2 mg tablet	• Take 2 mg PO once daily		
OTEZLA®	<input type="checkbox"/> 28 Day Starter Pack	<ul style="list-style-type: none"> • Day 1: Take 10 mg PO QAM • Day 2: Take 10 mg PO BID • Day 3: Take 10 mg PO QAM & 20 mg QPM • Day 4: Take 20 mg PO BID • Day 5: Take 20 mg PO QAM & 30 mg QPM • Day 6 and after: Take 30 mg PO BID 		
	<input type="checkbox"/> 30 mg tablet	• Take 30 mg PO twice daily		
ORENCIA®	<input type="checkbox"/> 125 mg/mL PFS	<input type="checkbox"/> 10 kg to less than 25 kg: Inject 50 mg SC once weekly		
	<input type="checkbox"/> 125 mg/mL ClickJect™ Autoinjector	<input type="checkbox"/> 25 kg to less than 50 kg: Inject 87.5 mg SC once weekly		
	<input type="checkbox"/> 50 mg/0.4 mL PFS	<input type="checkbox"/> ≥50 kg: Inject 125 mg SC once weekly		
	<input type="checkbox"/> 87.5 mg/0.7 mL PFS			
SIMPONI ARIA®	<input type="checkbox"/> 50 mg/4 mL SDV	• Infuse 2 mg/kg IV over 30 minutes at weeks 0 and 4, then every 8 weeks		
SIMPONI®	<input type="checkbox"/> 50 mg/0.5 mL PFS	<input type="checkbox"/> Inject 50 mg SC once per month		
	<input type="checkbox"/> Smartject® Autoinjector (50 mg/0.5 mL)			
STELARA®	<input type="checkbox"/> 45 mg/0.5 mL PFS	<input type="checkbox"/> Inject 45 mg SC at weeks 0 and 4, followed by 45 mg every 12 weeks		
	<input type="checkbox"/> 90 mg/mL PFS	<input type="checkbox"/> Inject 90 mg SC at weeks 0 and 4, followed by 90 mg every 12 weeks		
XELJANZ®	<input type="checkbox"/> 5 mg tabs	<input type="checkbox"/> Take 5 mg PO twice daily		
	<input type="checkbox"/> 11 mg XR tabs	<input type="checkbox"/> Take 11 mg PO daily		
TALTZ®	<input type="checkbox"/> 80 mg/mL Autoinjector	<input type="checkbox"/> Initial Dose: Inject 160 mg (two 80 mg injections) SC at week 0		
	<input type="checkbox"/> 80 mg/mL PFS	<input type="checkbox"/> Maintenance Dose: Inject 80 mg SC every 4 weeks		

Patient Support Programs: Please have patient sign and date to enroll in pharmaceutical company assisted patient support program.

Patient Signature _____ Date ____ / ____ / ____

Account Manager

Prescriber Authorization (No stamps. Signature and date must be completed in prescriber's handwriting. NY prescriptions must be submitted via e-script.)

I authorize US Bioservices Corporation to act as my representative and on behalf of myself and my patient to initiate any authorization processes from applicable health plans, if needed, including the submission of any necessary forms to such health plans.

Prescriber Signature-Substitution Permissible _____ **PRESCRIBER SIGNATURE REQUIRED. NO STAMPS.** Date ____ / ____ / ____

Prescriber Signature-Dispense as Written _____ **PRESCRIBER SIGNATURE REQUIRED. NO STAMPS.** Date ____ / ____ / ____