

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: _____ lb kg

2. Patient Insurance Information (Please fax front and back copy of all insurance cards - prescription and 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 and 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 (Ilaris, Kevzara, Olumiant, Otezla, Orencia, Rinvoq, Simponi Aria, Simponi, Stelara, Taltz and Xeljanz are available on Rheumatology Referral Form I-Z)

Medication	Dose / Strength	Directions	Dispense	Refills
ACTEMRA®	<input type="checkbox"/> 162 mg/0.9 mL PFS	<input type="checkbox"/> < 100 kg (220 lb): Inject 162 mg SC every other week <input type="checkbox"/> ≥ 100 kg (220 lb): Inject 162 mg SC qw		
	<input type="checkbox"/> 80 mg/4 mL SDV <input type="checkbox"/> 200 mg/10 mL SDV <input type="checkbox"/> 400 mg/20 mL SDV	<input type="checkbox"/> Infuse 4 mg/kg IV over 1 hour q4weeks, increase to 8 mg/kg q4weeks based on clinical response. Doses exceeding 800 mg per infusion are not recommended.		
BENLYSTA®	<input type="checkbox"/> 120 mg/5 mL SDV <input type="checkbox"/> 400 mg/20 mL SDV <input type="checkbox"/> 200 mg PFS <input type="checkbox"/> 200 mg Autoinjector	<input type="checkbox"/> Infuse 10 mg/kg IV (over 1 hour) at weeks 0, 2 and 4 and then q4weeks thereafter <input type="checkbox"/> Inject 200 mg SC once weekly		
	CIMZIA®	<input type="checkbox"/> 200 mg/mL PFS Kit <input type="checkbox"/> 200 mg/mL Starter Kit <input type="checkbox"/> 200 mg/mL Vial Kit	<input type="checkbox"/> Initial Dose: Inject 400 mg SC qw at weeks 0, 2 and 4 <input type="checkbox"/> Maintenance Dose: Inject 200 mg SC once q4weeks <input type="checkbox"/> Maintenance Dose: Inject 400 mg SC once q4weeks	
COSENTYX®	<input type="checkbox"/> 150 mg/mL PFS <input type="checkbox"/> 150 mg/mL Sensoready® Pen	<input type="checkbox"/> Initial Dose: Inject 300 mg SC weekly at weeks 0, 1, 2, 3 and 4 <input type="checkbox"/> Initial Dose: Inject 150 mg SC weekly at weeks 0, 1, 2, 3 and 4 <input type="checkbox"/> Maintenance Dose: Inject 150 mg SC q4weeks <input type="checkbox"/> Maintenance Dose: Inject 300 mg SC q4weeks		
	ENBREL®	<input type="checkbox"/> 25 mg PFS <input type="checkbox"/> 25 mg Vial <input type="checkbox"/> 50 mg PFS <input type="checkbox"/> 50 mg SureClick® Autoinjector <input type="checkbox"/> 50 mg Mini	<input type="checkbox"/> Inject 50 mg SC qw <input type="checkbox"/> Inject 0.8 mg/kg SC qw (max 50 mg per week if > 63 kg [138 lb]) <input type="checkbox"/> Inject 50 mg SC twice weekly for three months followed by 50 mg every week	
HUMIRA®	<input type="checkbox"/> 10 mg/0.1 mL PFS <input type="checkbox"/> 10 mg/0.2 mL PFS <input type="checkbox"/> 20 mg/0.2 mL PFS <input type="checkbox"/> 20 mg/0.4 mL PFS <input type="checkbox"/> 40 mg/0.4 mL PFS <input type="checkbox"/> 40 mg/0.8 mL PFS <input type="checkbox"/> 40 mg/0.4 mL Pen <input type="checkbox"/> 40 mg/0.8 mL Pen	<input type="checkbox"/> Rheumatoid Arthritis / Psoriatic Arthritis: Inject 40 mg SC (one 40 mg Pen) every other week Juvenile Idiopathic Arthritis: <input type="checkbox"/> 10 kg (22 lb) to <15 kg (33 lb): 10 mg every other week <input type="checkbox"/> 15 kg (33 lb) to < 30 kg (66 lb): 20 mg every other week <input type="checkbox"/> ≥ 30 kg (66 lb): 40 mg every other week		

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 ____ / ____ / ____