

Patient				
Patient name:				
Date of birth:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Height:	Weight:	lb kg
Address:		City:	State:	ZIP:
Home number:	Work number:	Cell number:	Best time to call: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	
Last 4 of SS :		Ethnicity:		
Primary language:		Allergies:		<input type="checkbox"/> No known drug allergies

Provider				
Physician name:		Practice name:		
State license number:		Drug Enforcement Administration (DEA) number:		
Address:		City:	State:	ZIP:
National Provider Identifier (NPI) number:		Phone:	Fax:	
Key office contact:		Phone:		

**Insurance**  
\*Please provide a copy of the insurance card (front and back)

Clinical information				
<input type="checkbox"/> Rheumatoid Arthritis (ICD: M06.9) <input type="checkbox"/> Psoriatic Arthritis (ICD: L40.50) <input type="checkbox"/> Ankylosing Spondylitis (ICD: M45.9) <input type="checkbox"/> Polyarticular Juvenile Rheumatoid Arthritis (ICD: M08.00) <input type="checkbox"/> Other (ICD: )				
TB/PPD Test: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	Test date:	Is patient taking methotrexate? <input type="checkbox"/> No <input type="checkbox"/> Yes	HBV Positive? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Previously treated: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list therapy:			Dates:	

Prescription information				
Medication	Dose/Strength	SIG	Quantity	Refills
<input type="checkbox"/> Actemra®	<input type="checkbox"/> 80mg/4mL <input type="checkbox"/> 200mg/10mL <input type="checkbox"/> 400mg/20mL <input type="checkbox"/> 162mg/0.9mL PFS <input type="checkbox"/> 162mg/0.9mL ACTPen	<input type="checkbox"/> Infuse mg IV over 1 hour every 4 weeks. <input type="checkbox"/> Inject 162mg SubQ every 2 weeks. <input type="checkbox"/> Inject 162mg SubQ every week	1 month	
<input type="checkbox"/> Cimzia®	200mg/mL <input type="checkbox"/> PFS <input type="checkbox"/> vial <input type="checkbox"/> Starter kit	<input type="checkbox"/> Starter Kit: 400mg SubQ at 0, 2, & 4 weeks <input type="checkbox"/> 400mg SubQ every 4 weeks <input type="checkbox"/> 200mg SubQ every 2 weeks	<input type="checkbox"/> Starter Kit 1 month	
<input type="checkbox"/> Cosentyx®	150mg/mL <input type="checkbox"/> Pen <input type="checkbox"/> PFS	<input type="checkbox"/> Inject 150 mg SubQ once weekly at weeks 0, 1, 2, 3, and 4; then, 150 mg subQ every 4 weeks. <input type="checkbox"/> Inject 150 mg subcutaneously every 4 weeks.	1 month	
<input type="checkbox"/> Enbrel®	<input type="checkbox"/> 25mg vial <input type="checkbox"/> 50mg Sureclick® Pen <input type="checkbox"/> 25mg PFS <input type="checkbox"/> 50mg PFS <input type="checkbox"/> 50mg Mini Cart	<input type="checkbox"/> Inject 25mg SubQ TWICE a week, 72 – 96 hours apart <input type="checkbox"/> Inject 50mg SubQ ONCE a week <input type="checkbox"/> Inject 50mg SubQ TWICE a week, 72 – 96 hours apart	1 month	
<input type="checkbox"/> Humira®	<input type="checkbox"/> 40mg/0.8ml PEN <input type="checkbox"/> 40mg/0.8ml PFS <input type="checkbox"/> 40mg/0.4ml PEN <input type="checkbox"/> 40mg/0.4ml PFS	<input type="checkbox"/> Inject 40mg SubQ ONCE a week <input type="checkbox"/> Inject 40mg SubQ every 2 weeks	1 month	
<input type="checkbox"/> Kevzara®	<input type="checkbox"/> 200mg/1.14mL PEN <input type="checkbox"/> 200mg/1.14mL PFS <input type="checkbox"/> 150mg/1.14mL PEN <input type="checkbox"/> 150mg/1.14mL PFS	<input type="checkbox"/> Inject 200 mg subcutaneously once every 2 weeks. <input type="checkbox"/> Inject 150 mg subcutaneously once every 2 weeks.	1 month	
<input type="checkbox"/> Remicade® <input type="checkbox"/> Renflexis <input type="checkbox"/> Inflectra	<input type="checkbox"/> 100mg vial Dose: mg/kg	<input type="checkbox"/> Initial: Infuse mg IV at 0, 2, & 6 weeks then mg every weeks <input type="checkbox"/> Maintenance: Infuse mg IV every weeks	vial(s)	
<input type="checkbox"/> Rinvoq	<input type="checkbox"/> 15mg tablet	<input type="checkbox"/> Take 1 tablet by mouth once daily, with or without food	1 month	
<input type="checkbox"/> Rituxan®	<input type="checkbox"/> 500mg/50mL <input type="checkbox"/> 100mg/10mL	<input type="checkbox"/> Infuse 1000mg IV on days 1 and 15 then every 6 months. <input type="checkbox"/> Other: _____	vial(s)	
<input type="checkbox"/> Simponi®	<input type="checkbox"/> 50mg Pen <input type="checkbox"/> 50mg PFS	<input type="checkbox"/> 50mg SubQ q month	1 month	
<input type="checkbox"/> Simponi Aria®	<input type="checkbox"/> 50mg/4mL vial	<input type="checkbox"/> Infuse 2mg/kg IV over 30 mins at weeks 0 & 4, then Q 8 weeks. <input type="checkbox"/> Infuse 2mg/kg IV every 8 weeks	1 month	
<input type="checkbox"/> Stelara®	<input type="checkbox"/> 45mg/0.5mL PFS <input type="checkbox"/> 90mg/mL PFS	<input type="checkbox"/> Initial: Inject 45mg SubQ at weeks 0 and 4 <input type="checkbox"/> Maintenance: Inject 45mg SubQ every 12 weeks With coexistent plaque psoriasis and >100kg: <input type="checkbox"/> Initial: Inject 90mg SubQ at weeks 0 and 4 <input type="checkbox"/> Maintenance: Inject 90mg SubQ every 12 weeks	1 month	
<input type="checkbox"/> Taltz	<input type="checkbox"/> 80mg PFS <input type="checkbox"/> 80mg PEN	<input type="checkbox"/> Starting Dose: Inject two 80 mg injections SQ on Day 1 <input type="checkbox"/> Maintenance Dose: Inject one 80 mg injection SQ every 4 weeks	<input type="checkbox"/> 2 Dose Pak <input type="checkbox"/> 1 Dose Pak	
<input type="checkbox"/> Olumiant®	<input type="checkbox"/> 2mg tablet	<input type="checkbox"/> Take 1 tablet by mouth once daily, with or without food	1 Month	
<input type="checkbox"/> Orencia	<input type="checkbox"/> 125mg PFS <input type="checkbox"/> 125mg Clickjet <input type="checkbox"/> 87.5mg PFS <input type="checkbox"/> 50mg PFS <input type="checkbox"/> 250mg vial	<input type="checkbox"/> Inject 125mg SubQ every week <input type="checkbox"/> Inject 87.5mg SubQ every week <input type="checkbox"/> Inject 50mg SubQ every week <input type="checkbox"/> Infuse mg IV at 0, 2, & 4 weeks <input type="checkbox"/> Infuse mg IV every 4 weeks	vial(s)	
<input type="checkbox"/> Otezla	<input type="checkbox"/> 28 day Starter Kit <input type="checkbox"/> 30mg Tablet	<input type="checkbox"/> Initial: Take as directed on starter package; Maintenance: 30mg twice daily starting day 6 <input type="checkbox"/> Take 1 tablet by mouth twice daily		
<input type="checkbox"/> Xeliaz® <input type="checkbox"/> Xeliaz XR®	<input type="checkbox"/> 5mg tablet <input type="checkbox"/> 11mg tablet	<input type="checkbox"/> Take 1 tablet by mouth twice daily with or without food <input type="checkbox"/> Take 1 tablet by mouth once daily, with or without food	1 month	
<input type="checkbox"/> Other				

PRESCRIBER SIGNATURE: PRESCRIBER SIGNATURE IS REQUIRED TO VALIDATE PRESCRIPTIONS. (STAMPS NOT ACCEPTED)

Prescriber signature: \_\_\_\_\_ o Dispense as written Do not substitute o Substitution permitted/Branded exchange permitted Date: \_\_\_\_\_

For states requiring handwritten expressions of product selection, use this area (eg. medically necessary, may not substitute, dispense as written, etc)  
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