Procare PHARMACY

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# Rheumatoid Arthritis Prescription Referral Form ( Form 5A)

**Date Medication Needed:** _____ **Ship To:** Patient's Home Prescriber's Office Pick-up (store location): _____ Injection training by pharmacy?

## 1: Patient Information

**Patient Name:** **Birthdate:** **Sex:** Male Female **Height:** **Weight:** lbs. kg.

**Soc. Sec. #:** **Preferred Phone:** **Known Allergies:** _____

**Address:** **City:** **State:** **Zip:** _____

**Alternate Caregiver Name:** **Preferred Phone:** _____

**Insurance Information:** Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)

## 2: Prescriber Information

**Provider Name:** **DEA#:** **NPI#:** **Tax ID#:** _____

**Address:** **Phone:** **Fax:** _____

**City, State, Zip:** **Key Contact:** **Phone:** _____

## 3: Diagnosis/Clinical Information | *Please FAX recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization*

**Diagnosis:**

**Other:** _____

**Prior failed medications** (medication and duration of treatment/reason for d/c):

_____

**Is patient currently on RA therapy?** Yes No

Medications: _____

**TB/PPD test given?** Yes No

**BMD/T-score:** _____ **Date:** _____

**Does patient have a latex allergy?** Yes No

**Is Patient at risk for osteoporotic fracture as evident by any of the following?**

History of osteoporotic fracture Site: _____ Date: _____

Patient has tried and failed an oral bisphosphonate

Patient has documented contraindication/is intolerant to oral bisphosphonate therapy (please submit a copy of DEXA w/prescription)

## 4: Prescription Information | *Xeljanz NOT to be used in combination with biologic DMARD's*

| Medication | Dose/Strength | Sig | Qty. | Refills |
|---|---|---|---|---|
| **Enbrel®** | 50mg/ml SureClick™ Autoinjector<br>50mg/ml Prefilled Syringe<br>25mg/0.5ml Prefilled Syringe | Inject 50mg SC ONCE a week<br>Inject 25mg TWICE a week, 72 to 96 hours apart<br>**Other:** | 4-week supply | |
| **Forteo®** | 600mcg/2.4ml PFS | Inject 20mcg SC, as directed, once daily | 4-week supply | |
| **Pen Needles** | 31 gauge 6mm | | 28 needles | |
| **Humira®**<br>Injection training from My Humira ***(patient must sign below)*** | 40mg/0.8ml Pen<br>40mg/0.8ml Prefilled Syringe | Inject 40mg SC every OTHER week<br>Inject 40mg SC ONCE a week | 4-week supply | |
| **Otezla®** | | | | |
| **Prolia®** | 60mg Prefilled Syringe | Inject 60mg SC ONCE every 6 months | | |
| **Simponi®** | 50mg/0.5ml Prefilled Syringe<br>50mg/0.5ml Autoinjector | Inject 50mg ONCE a month | 4-week supply | |
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**PRIOR AUTHORIZATION APPLICATION TO INSURANCE AND PATIENT SUPPORT PROGRAM ARE AVAILABLE AT PROCARE PHARMACY**

**Prescriber Signature:** Prescriber, please sign and date below

Dispense as written Date Substitution Permissable Date



**Pursuant to VA/OH/MO/VT law, only 1 medication is permitted per order form. Please use a new form for additional items.**

**# of Prescriptions:** _____