Rheumatology (A-K)

Phone: 417-719-4510
Fax: 417-893-3908
specialty.alpspharmacy.com

PATIENT INFORMATION

Patient Name: _____
Address: _____
City, State, ZIP: _____
Home Phone: _____ Alternate Phone: _____
Caregiver: _____ Email: _____
DOB: _____ Social Security#: _____
Gender: ☐ Male ☐ Female Comorbidities: _____
Height: _____ Weight: _____ Allergies: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____
Address: _____
City, State, ZIP: _____
Phone: _____ Fax: _____
NPI: _____ Tax ID: _____
DEA: _____
Office Contact: _____ Phone: _____
Contact Email: _____

INSURANCE INFORMATION

Please fax a copy of patients' insurance cards (prescription and medical, FRONT and BACK) including any secondary insurance.

CLINICAL INFORMATION [Please fax all pertinent clinical and lab information and/or attach separate sheet if needed.]

Diagnosis:
☐ M06.9 (RHEUMATOID ARTHRITIS)
☐ L40.54 (PSORIATIC JUVENILLE ARTHRITIS)
☐ M08.0 (JUVENILLE IDIOPATHIC ARTHRITIS)
☐ M45.9 (ANKYLOSING SPONDYLITIS)
☐ L40.5 (PSORIATIC ARTHRITIS)
☐ _____
☐ _____

Date of Diagnosis: _____

TB test?: ☐ Yes ☐ No Negative Test Date: _____

HBV positive?: ☐ Yes ☐ No If yes, currently treated? ☐ Yes ☐ No

Concomitant Medications: _____

Additional Information: _____

Prior Therapy ☐ Yes ☐ No	Approx. Therapy Start/End Dates	Reason for Discontinuation of Therapy
☐ 5-ASA	_____ to _____	
☐ Actemra	_____ to _____	
☐ Immunosuppressants (6-MP or other)	_____ to _____	
☐ Corticosteroids	_____ to _____	
☐ Cosentyx	_____ to _____	
☐ Methotrexate	_____ to _____	
☐ Cimzia	_____ to _____	
☐ Enbrel	_____ to _____	
☐ Humira	_____ to _____	
☐ Orencia	_____ to _____	
☐ Otezla	_____ to _____	
☐ Remicade	_____ to _____	
☐ Simponi	_____ to _____	
☐ Stelara	_____ to _____	
☐ Xeljanz	_____ to _____	
☐ Other:	_____ to _____	

PRESCRIPTION INFORMATION

Medication	Directions	Quantity		Refills
☐ Actemra®	☐ 162 mg Sub-Q every other week ☐ 162 mg Sub-Q once a week	☐ 2 x 162 mg/ 0.9 mL PFS ☐ 4 x 162 mg/ 0.9 mL PFS	☐ PFS	
☐ Cimzia®	☐ 400 mg Sub-Q at weeks 0, 2 and 4	☐ 1 kit = 6x200 mg/mL	☐ PFS	
	☐ 400 mg Sub-Q every 4 weeks ☐ 200 mg Sub-Q every 2 weeks	☐ 1 carton = 2 x 200 mg/mL	☐ PFS	
☐ Cosentyx®	☐ Inject 150 mg sub-Q once weekly at weeks 0, 1, 2 and 3 ☐ Inject 300 mg sub-Q once weekly at weeks 0, 1, 2 and 3	☐ 4 x 150 mg/mL ☐ 8 X 150 mg/mL	☐ Sensoready® Pen ☐ PFS	
	☐ Inject 150 mg subcut on day 29 and every 4 weeks thereafter ☐ Inject 300 mg subcut on day 29 and every 4 weeks thereafter	☐ 1 x 150 mg/mL ☐ 2 x 150 mg/mL	☐ Sensoready® Pen ☐ PFS	
☐ Enbrel®	☐ Inject 50 mg Sub-Q once a week ☐ Other: _____	☐ 4 x 50 mg/mL ☐ 4 x 25 mg/mL ☐ Other: _____	☐ SureClick® ☐ PFS ☐ Other: _____	
☐ Humira® (adalimumab)	☐ Inject 40 mg Sub-Q every other week ☐ Other: _____	☐ 1 Carton = 2 x 40 mg/0.8mL ☐ Other: _____	☐ Pen ☐ PFS	
☐ Humira® Citrate-Free (adalimumab)	☐ Inject 40 mg Sub-Q every other week ☐ Other: _____	☐ 1 Carton = 2 x 40 mg/0.4mL ☐ Other: _____	☐ Pen ☐ PFS	
☐ Kevzara®	☐ Inject 150mg Sub-Q every 2 weeks ☐ Inject 200mg Sub-Q every 2 weeks	☐ 2 x 150mg / 1.14ml PFS ☐ 2 x 200mg / 1.14ml PFS	☐ PFS	

☐ Other Medication: _____ Dose: _____ Quantity: _____ Refills: _____
Direction(s): _____

INJECTION TRAINING

☐ To Be Administered by Pharmacist ☐ Pharmacist to Provide Training ☐ Patient Trained in MD Office ☐ Manufacturer Nurse Support

PRESCRIPTION DELIVERY

☐ Patient's Home ☐ Physician's Office ☐ Patient Will Pick Up in Pharmacy Date Issued: _____ Needs by Date: _____

PRESCRIBER AUTHORIZATION

I authorize Alps Pharmacy, including it's representatives and subcontractors, to act as my agent to initiate and execute the insurance prior authorization, patient assistance, and nursing programs. If Alps Pharmacy is unable to fulfill this prescription, I authorize Alps Pharmacy to forward this information and data related to the coverage of this prescription to another pharmacy.

Prescriber's Signature: _____ Date: _____ Prescriber's Signature: _____ Date: _____

PRODUCT SUBSTITUTION PERMITTED ***Dispense As Written***

CONFIDENTIALITY NOTICE

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