

### Patient Information

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex:  Male  Female SSN: \_\_\_\_\_ Wt (kg/lbs): \_\_\_\_\_ Ht (cm/in): \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_ Alternate: \_\_\_\_\_

Caregiver Name: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_ Phone: \_\_\_\_\_

Insurance Plan: \_\_\_\_\_ Plan ID: \_\_\_\_\_ BIN #: \_\_\_\_\_ PCN #: \_\_\_\_\_ GRP #: \_\_\_\_\_

Please fax a copy of the front and back of the insurance card(s).

### Prescriber + Shipping Information

Prescriber Name: \_\_\_\_\_ DEA: \_\_\_\_\_ NPI: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Alternate: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

If shipping to prescriber:  First Fill  Always  Never

### Clinical Information (Please fax all pertinent clinical and lab information)

**Diagnosis:**  M06.9 (Rheumatoid Arthritis)  M08.0 (Juvenile Idiopathic Arthritis)  L40.59 (Psoriatic Arthritis)  L40.54 (Psoriatic Juvenile Arthritis)  M45.9 (Ankylosing Spondylitis)  \_\_\_\_\_

Diagnosis Date: \_\_\_\_\_ TB Test:  Yes  No Negative Test Date: \_\_\_\_\_

| Prior Therapy <input type="checkbox"/> Yes <input type="checkbox"/> No | Reason for Discontinuation of Therapy | Start Date | End Date |
|--|---------------------------------------|------------|----------|
|  |                                       |            |          |
|  |                                       |            |          |
|  |                                       |            |          |

Comorbidities: \_\_\_\_\_

Concomitant Medications: \_\_\_\_\_

Allergies:  NKDA  Other: \_\_\_\_\_

### Prescription

### Directions, Quantity, Form

### Refill

|   |  |  |                                     |
|---|--|--|-------------------------------------|
| <input type="checkbox"/> <b>Inflectra</b> <sup>®</sup><br>(infliximab)<br><input type="checkbox"/> <b>Remicade</b> <sup>®</sup><br>(infliximab)<br><input type="checkbox"/> <b>Renflexis</b> <sup>®</sup><br>(infliximab) | <input type="checkbox"/> Inject _____ mg (5mg/kg x _____ kg) IV at 0, 2, and 6 weeks, then every _____ weeks thereafter  |  |                                     |
|   | <input type="checkbox"/> In conjunction with Methotrexate: Inject _____ mg (3mg/kg x _____ kg) IV at 0, 2, and 6 weeks, then every _____ weeks thereafter  |  |                                     |
| <input type="checkbox"/> <b>Krystexxa</b> <sup>®</sup><br>(pegloticase injection)<br>8mg/mL   | <input type="checkbox"/> Inject 8mg via intravenous infusion every 2 weeks   |  |                                     |
| <input type="checkbox"/> <b>Methotrexate</b> <sup>®</sup>   | <input type="checkbox"/> Inject _____ mL subq every 7 days at the same time each week  | <input type="checkbox"/> 25mg/mL Injectable Solution |                                     |
| <input type="checkbox"/> <b>Orencia</b> <sup>®</sup><br>(abatacept)   | <input type="checkbox"/> Infuse _____ mg at week 0 <b>only</b>   | <input type="checkbox"/> _____ x 250 mg              | <input type="checkbox"/> Vials<br>0 |
|   | <input type="checkbox"/> Infuse _____ mg at weeks 0 and 2<br><i>(JIA &lt;75 kg: 10 mg/kg; JIA ≥75 kg or RA: &lt;60 kg: 500 mg, 60-100 kg: 750 mg; &gt;100 kg: 1000 mg)</i>                       |  |                                     |
|   | <input type="checkbox"/> Infuse _____ mg at week 4 and every 4 weeks thereafter<br><i>(JIA &lt;75 kg: 10 mg/kg; JIA ≥75 kg or RA: &lt;60 kg: 500 mg, 60-100 kg: 750 mg; &gt;100 kg: 1000 mg)</i> | <input type="checkbox"/> _____ x 250 mg              | <input type="checkbox"/> Vials      |
| <input type="checkbox"/> <b>Simponi Aria</b> <sup>®</sup><br>(golimumab)  | <input type="checkbox"/> Infuse _____ mg (2 mg/kg x _____ kg) over 30 minutes at weeks 0   | <input type="checkbox"/> _____ x 50 mg/4ml           | <input type="checkbox"/> Vials<br>0 |
|   | <input type="checkbox"/> Infuse _____ mg (2 mg/kg x _____ kg) over 3 minutes at week 4 and every 8 weeks thereafter  | <input type="checkbox"/> _____ x 50 mg/4ml           |                                     |

Injection Training Provided by:  Prescriber's Office  Pharmacy  Other: \_\_\_\_\_

Per state-specific law, prescriptions will be dispensed as generic, if applicable, unless notated otherwise: \_\_\_\_\_

Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I authorize AmeriPharma and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time by providing written notice to AmeriPharma.

Confidentiality Statement: This message is intended only for the individual or entity to which it is addressed. It may contain information which may be proprietary and confidential. It may also contain privileged, confidential information which is exempt from disclosure under applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA). If you are not the intended recipient, please note that you are strictly prohibited from disseminating or distributing this information (other than to the intended recipient) or copying this information. If you received this communication in error, please notify the sender immediately by calling 877-778-0318 to obtain instructions as to the proper destruction of the transmitted material. Thank you.