



Rheumatology Order Form
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 www.transcriptpharmacy.com

Patient Information

Patient name _____
 Address _____
 City _____ State _____ Zip _____
 Home phone _____ Cell _____
 DOB _____ SSN _____
 Drug allergies _____ Male Female

Prescriber Information

Prescriber name _____ Lic# _____
 DEA# _____ Tax ID _____
 Practice name _____
 Address _____ Suite _____
 City _____ State _____ Zip _____
 Office Phone _____ Fax _____

Insurance, Medicare or Medicaid Information

Primary Insurance _____ Secondary Insurance (*If applicable*) _____
 Policy # _____ Group _____ Policy # _____ Group _____
 Insurance phone _____ Insurance phone _____
 Prescription Drug Coverage: Company _____ Phone _____
 RXGRP# _____ RXBIN# _____ PCN/ID# (if avail.) _____
 COMPLETE OR FAX FRONT AND BACK COPIES OF INSURANCE, PRESCRIPTION AND/OR CO-PAY ASSISTANCE CARD(S)

Clinical Information

Primary diagnosis _____ ICD-9 _____ Patient weight _____ lbs or kgs (please circle) TB/PPD test given? Yes No
 Prior Treatments: 5-ASA Azathioprine Azulfidine Celebrex Corticosteroids Gold Salts Immunosuppressants MTX NSAIDS Penicillamine Plaquenil
 Previous biologic _____ Other _____
 Additional medical justification _____
 Currently on a biologic? Yes No How long? _____ Date of last dose ____/____/____ This Rx is: New therapy Continuing previous treatment on this agent

Drug Name	Prescription Orders (PLEASE CHECK ONE OR MORE)	Quantity	Refills
<input type="radio"/> Cimzia®	<input type="radio"/> Initial dose of 400mg SC at weeks 0, 2 and 4, followed by: <input type="radio"/> Maintenance dose of 400mg SC every 4 weeks [OR] <input type="radio"/> Maintenance dose of 200mg SC every 2 weeks	28 day supply	Refills
Enbrel® 50mg/ml <input type="radio"/> SureClick Auto-Injector <input type="radio"/> PFS (prefilled syringes)	<input type="radio"/> Inject 50mg SC once weekly <input type="radio"/> Other: _____	28 day supply	Refills
Enbrel® 25mg/0.5ml <input type="radio"/> Pre-filled syringe <input type="radio"/> Vial kit	<input type="radio"/> Inject 25mg SC twice weekly <input type="radio"/> Other: _____	28 day supply	Refills
Humira® <input type="radio"/> Pen <input type="radio"/> Syringe	<input type="radio"/> 40mg SC every other week [OR] <input type="radio"/> Increased frequency of 40mg SC once weekly for patients NOT receiving MTX	28 day supply	Refills
<input type="radio"/> Simponi®	<input type="radio"/> Inject 50 mg SC once per month with SmartJect® auto injector [OR] <input type="radio"/> 50mg SC once per month (PFS)	30 day supply	Refills
<input type="radio"/> Orencia® (Check one or both in the next box)	<input type="radio"/> INFUSION: Initial dose _____mg by IV Infusion (No Refill) <input type="radio"/> SUBCUTANEOUS: Inject 125mg SQ weekly (first dose, one day after infusion)	28 day supply	Refills
Other medication	Directions	Qty	Refills

Deliver to: Patient's home MD's office 1st dose to MD's office, remaining refills to patient home Injection training needed? Yes No

We authorize Transcript Pharmacy, its employees and agents, to assist with delegated prior authorization requests to the fullest extent allowable by law and insurer guidelines.

 Prescriber signature Office contact name (Nurse, MA, Other) Preferred phone number & extension Date