Community Memorial Pharmacy
P: 844-236-8311
F: 805-948-5176

Community Memorial HEALTHCARE

☐ **New/Changed Dose**

Rheumatology (A-E) Actemra®, Benlysta®, Bimzelx®, Cimzia® Cosentyx®, Enbrel®

Prescriber Information

Prescriber Name _____ ☐ MD ☐ DO ☐ NP ☐ PA NPI _____

Office Contact _____ Practice Name / Collaborating MD _____

Address _____ City _____ State _____ Zip _____

Phone _____ Fax _____

Patient Information • PLEASE SEND COPY OF INSURANCE CARD

Patient's Name _____ Last 4 Digits of SS# _____ DOB / /

Sex ☐ M ☐ F Weight _____ Height _____ Diabetic? ☐ Y ☐ N

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work/Cell _____ HIPAA Contact _____

Emergency # _____

Interpreter Needed? ☐ Y ☐ N | Allergies ☐ Y ☐ N If Yes, list allergies _____

Insurance Information

Primary Insurance _____ Policy ID _____ Group# _____

BIN _____ PCN _____

Policyholder Name _____ Policyholder DOB / /

Clinical Information • PLEASE SEND COPY OF MEDICAL AND PRESCRIPTION INSURANCE CARDS, PROGRESS NOTES AND LAB REPORTS, SUPPORTING DIAGNOSIS, CO-MORBIDITIES, AND LAB VALUES

Diagnosis ☐ M32.9 Active Systemic Lupus Erythematosus ☐ M45.9 Ankylosing Spondylitis
☐ M08.0 Juvenile Idiopathic Arthritis ☐ L40.59 Psoriatic Arthritis ☐ L40.54 Psoriatic Juvenile Arthritis
☐ M06.9 Rheumatoid Arthritis ☐ M45.A _____ Non-Radiographic Axial Spondyloarthritis
☐ Other _____

Date Diagnosis / / Date of Neg. TB Test / /

Any prior treatment? ☐ Y ☐ N If Yes, provide information below.

Prior Therapy _____

Reason for Discontinuation of Therapy _____ Approx. Start Date / /
Approx. End Date / /

Comorbidities _____

Concomitant Medications _____

Allergies ☐ NKDA ☐ Other _____

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Prescription Information

Medication	Quantity/Dose	Sig	Refills
☐ **ACTEMRA®** ☐ PFS ☐ ACTPen®	☐ 2 cartons (2x162 mg/0.9 ml) ☐ 4 cartons (4x162 mg/0.9 ml)	☐ Inject 162 mg SQ every other week (<100 kg) ☐ Inject 162 mg SQ every week (>100 kg)	
☐ **BENLYSTA®** ☐ PFS ☐ Pen	☐ 1 carton (4x200 mg/ml autoinjector) ☐ 1 carton (4x200 mg/ml PFS)	☐ Maintenance Dose: Administer 200 mg SQ once every week	
☐ **BIMZELX®** ☐ PFS ☐ Pen	☐ 1 carton (1x160 mg/ml)	☐ Inject 160 mg SQ every 4 weeks	
☐ **CIMZIA®** *Adults ☐ PFS ☐ Vial	☐ PFS Only: Starter Kit (6x200 mg/ml)	☐ Starter Dose: Inject 400 mg SQ at weeks 0, 2, and 4	No Refills
	☐ 1 carton (2x200 mg/ml)	☐ Maintenance Dose: Inject 400 mg SQ every 4 weeks ☐ Maintenance Dose: Inject 200 mg SQ every 2 weeks	
☐ **CIMZIA®** *Pediatrics (age 2 & older)	☐ 2 cartons (4x200 mg) vials ☐ 3 cartons (6x200 mg) vials ☐ 3 cartons (6x200 mg/ml) PFS	Starter Dose: ☐ Weight 10-19 kg: Inject 100 mg SQ at weeks 0, 2 and 4. ☐ Weight 20-39 kg: Inject 200 mg SQ at weeks 0, 2 and 4. ☐ Weight ≥ 40 kg: Inject 400 mg SQ at weeks 0, 2 and 4.	No Refills
	☐ 1 carton (2x200 mg) vials ☐ 1 carton (2x200 mg/ml) PFS	Maintenance Dose: ☐ Weight 10-19 kg: Inject 50 mg SQ every 2 weeks. ☐ Weight 20-39 kg: Inject 100 mg SQ every 2 weeks. ☐ Weight ≥ 40 kg: Inject 200 mg SQ every 2 weeks	
☐ **COSENTYX®** *Pediatrics (age 2 & older)	☐ 4 cartons (4x75 mg/0.5 ml) PFS ☐ 4 cartons (4x150 mg/ml) PFS ☐ 4 cartons (4x150 mg/ml) PEN	Starter Dose: ☐ Weight 15-49 kg: Inject 75 mg SQ at weeks 0, 1, 2 and 3. ☐ Weight ≥ 50 kg: Inject 150 mg SQ at weeks 0, 1, 2 and 3.	No Refills
	☐ 1 carton (1x75 mg/0.5ml) PFS ☐ 1 carton (1x150 mg/ml) PFS ☐ 1 carton (1x150 mg/ml) PEN	Maintenance Dose: ☐ Weight 15-49 kg: Inject 75 mg SQ every 4 weeks beginning on Day 29. ☐ Weight ≥ 50 kg: Inject 150 mg SQ every 4 weeks beginning on Day 29.	

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Prescription Information

Medication	Quantity/Dose	Sig	Refills
☐ **COSENTYX®** *Adults ☐ PFS ☐ Sensoready® Pen/Unoready® Pen	☐ 4 cartons (8x150 mg/ml) ☐ 4 cartons (4x150 mg/ml) ☐ 4 cartons (4x300 mg/2 ml)	☐ Starter Dose: Inject 300 mg SQ at weeks 0, 1, 2, 3 ☐ Starter Dose: Inject 150 mg SQ at weeks 0, 1, 2, 3	No Refills
	☐ 1 carton (2x150 mg/ml) ☐ 1 carton (1x150 mg/ml) ☐ 1 carton (1x300 mg/2 ml)	☐ Maintenance Dose: Inject 300 mg SQ every 4 weeks beginning on Day 29 ☐ Maintenance Dose: Inject 150 mg SQ every 4 weeks beginning on Day 29	
☐ **ENBREL®** ☐ Mini™ ☐ PFS ☐ SureClick® ☐ Vial	☐ 1 carton (4 x 50 mg/ml) ☐ Other:	☐ Inject 50 mg SQ every week ☐ Other Regimen:	

Injection Training

☐ Patient received injection training ☐ Prescriber's office to provide injection training
☐ Community Memorial Healthcare to coordinate injection training

By signing this form and utilizing our services, you are authorizing Community Memorial Healthcare and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber Signature _____ *Substitution Permitted*
Date _____

Prescriber Signature _____ *Dispense as Written*
Date _____

If brand is required, please write "DAW" in the box to the right. ☐