

New/Changed Dose**Rheumatology (R-S) Rasuvo®, Rinvoq™, Simponi®, Stelara® Adults, Stelara® Pediatrics****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 _____

Prescription Information

Medication	Quantity/Dose	Sig	Refills
RASUVO® Auto-Injector	4x7.5 mg/0.15 ml 4x10 mg/0.20 ml 4x12.5 mg/0.25 ml 4x15 mg/0.30 ml 4x17.5 mg/0.35 ml 4x20 mg/0.4 ml 4x22.5 mg/0.45 ml 4x25 mg/0.50 ml 4x30 mg/0.60 ml	Inject _____ mg SQ every week	
RINVOQ™ *Adults	15 mg tablet (30 day supply)	Take 1 tablet by mouth once daily	
RINVOQ™ *Pediatrics	1 mg/ml oral solution (quantity QS for 30 day supply in multiples of 180 ml) 15 mg tablet (30 day supply)	Weight 10-19 kg: Take 3 mg (3 ml oral solution) by mouth two times daily Weight 20-29 kg: Take 4 mg (4 ml oral solution) by mouth two times daily Weight ≥ 30 kg: Take 6 mg (6 ml oral solution) by mouth twice daily Take 15 mg (one 15 mg tablet) by mouth once daily	
SIMPONI® SmartJect® PFS	1 carton (1x50 mg/0.5 ml)	Inject 50 mg SQ once every month	
SKYRIZI™ PFS Pen	1 carton (150 mg/ml)	Starter Dose: Inject 150 mg SQ at weeks 0 and 4	1 Refills
	1 carton (150 mg/ml)	Maintenance Dose: Inject 150 mg SQ every 12 weeks	
STELARA® *Adults Patient eligible for self-injection? Y N	1 carton (1x45 mg/0.5 ml) 1 carton (1x90 mg/ml)	Starter Dose: Inject 45 mg SQ on day 1 (<100 kg) Starter Dose: Inject 90 mg SQ on day 1 (>100 kg)	No Refills
		Maintenance Dose: Inject 45 mg SQ on day 29 and every 12 weeks thereafter (<100 kg) Maintenance Dose: Inject 90 mg SQ on day 29 and every 12 weeks thereafter (>100 kg)	

Prescription Information

Medication	Quantity/Dose	Sig	Refills
STELARA® *Pediatrics	1 carton (1x45 mg/0.5mL) PFS 1 carton (1x90 mg/mL) PFS	Starter Dose: Patients <60 kg: Inject 0.75 mg/kg SQ on day 1 Patients 60 kg-100 kg: Inject 45 mg SQ on day 1 Patients >100 kg: Inject 90 mg SQ on day 1	No Refills
	1 carton (1x45 mg/0.5mL) PFS 1 carton (1x90 mg/mL) PFS 1 vial (45 mg/0.5 mL)	Maintenance Dose: Patients <60 kg: Inject 0.75 mg/kg SQ once every 12 weeks, starting on day 29 Patients 60 kg-100 kg: Inject 45 mg SQ once every 12 weeks, starting on day 29 Patients >100 kg: Inject 90 mg SQ once every 12 weeks, starting on day 29	

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.