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

Community Memorial HEALTHCARE

☐ **New/Changed Dose**

Rheumatology (T-Z) Taltz®, Tremfya®, Tyenne®, Xeljanz®, Xeljanz® XR

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
☐ M31. _____ Giant Cell Arteritis ☐ 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
☐ **TALTZ®** ☐ Pen ☐ PFS	☐ 1 carton (2x80 mg/ml)	☐ Starter Dose: Inject 160 mg SQ at week 0	No Refill
	☐ 1 carton (1x80 mg/ml)	☐ Maintenance Dose: Inject 80 mg SQ every 4 weeks	
☐ **TREMFYA®** ☐ Pen ☐ PFS	☐ 1 carton (1x100 mg/ml)	☐ Starter Dose: Inject 100 mg SQ at weeks 0 and 4	1 Refill
	☐ 1 carton (1x100 mg/ml)	☐ Maintenance Dose: Inject 100 mg SQ every 8 weeks	
☐ **TYENNE®** (tocilizumab-aazg) *Pediatrics (age 2 & up) ☐ Pen ☐ PFS	☐ 1 carton (1x162 mg/0.9 ml) ☐ 2 cartons (2x162 mg/0.9 ml) ☐ 4 cartons (4x162 mg/0.9 ml)	Weight < 30 kg: ☐ Inject 162 mg SQ once every 3 weeks ☐ Inject 162 mg SQ once every 2 weeks Weight ≥ 30 kg: ☐ Inject 162 mg SQ once every 2 weeks ☐ Inject 162 mg SQ once every week	
☐ **TYENNE®** (tocilizumab-aazg) *Adults ☐ Pen ☐ PFS	☐ 2 cartons (2x162 mg/0.9 ml)	☐ Starter Dose (RA patients < 100 kg only): Inject 162 mg SQ every other week	
	☐ 4 cartons (4x162 mg/0.9 ml)	☐ Maintenance Dose: Inject 162 mg SQ once every week	
☐ **XELJANZ®** *Pediatrics (age 2 & up)	☐ 5 mg tablets (60 tablets) ☐ 1 mg/ml oral solution (quantity QS for 30 day supply in multiples of 240 ml)	☐ Weight 10-19 kg: Take 3.2 mg (3.2 ml oral solution) by mouth two times daily ☐ Weight 20-39 kg: Take 4 mg (4 ml oral solution) by mouth two times daily ☐ Weight ≥ 40 kg: Take 5 mg by mouth two times daily	
☐ **XELJANZ®**	☐ 5 mg tablets (60 tablets)	☐ Take 1 tablet (5 mg) by mouth twice a day	
☐ **XELJANZ® XR**	☐ 11 mg tablets (30 tablets)	☐ Take 1 tablet (11 mg) by mouth every day	

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. ☐