TODT HILL PHARMACY

SPECIALTY PHARMACY

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RHEUMATOLOGY

DATE NEEDED BY .... SHIP to ☐ PATIENT ☐ OFFICE ☐ OTHER ....

PATIENT INFORMATION

PATIENT NAME ____

ADDRESS ____

CITY ______________________ STATE ______ ZIP ____________

MAIN PHONE____________________ALTERNATE PHONE_____________

SS# ______________________DOB_____________________

☐ MALE ☐ FEMALE HEIGHT __________ WEIGHT __________ AGE _____

PRESCRIBER INFORMATION

PRESCRIBER NAME ____

DEA # _________ NPI ___________ STATE LICENSE# _______________

GROUP|HOSPITAL ____

ADDRESS____

CITY, STATE, ZIP ____

MAIN PHONE ______________________ FAX______________________

CONTACT PERSON __________________ PHONE ___________________

PLEASE FAX COPY OF ☐ PRESCRIPTION CARD FRONT AND BACK ☐ CLINICAL NOTES ☐ MEDICAL CARD FRONT AND BACK

CLINICAL INFORMATION

DIAGNOSIS ☐ M06.9 RHEUMATOID ARTHRITIS ☐ L40.50 PSORIATIC ARTHRITIS ☐ M45.9 ANKYLOSING SPONDYLITIS ☐ M32 10 SYSTEMIC LUPUS ERYTHEMATOSUS

☐ H20.9 UVEITIS ☐ M08.3 JUVENILE IDIOPATHIC ARTHRITIS ☐ OTHER ____________________ DX CODE ___________________

LOCATION JOINTS ☐ HANDS ☐ FEET ☐ KNEE ☐ SPINE SKIN %BSA ____________________ ☐ HANDS ☐ FEET ☐ SCALP ☐ GRAIN ☐ NAILS ☐ OTHER

DRUG ALLERGIES ____

PRIOR FAILED MEDS ☐ METHOTREXATE LENGTH OF TREATMENT ___________ REASON FOR DISCONTINUING ______________________________

☐ OTEZLA LENGTH OF TREATMENT ___________ REASON FOR DISCONTINUING ______________________________

☐ ___________________ LENGTH OF TREATMENT ___________ REASON FOR DISCONTINUING ______________________________

DOES PATIENT HAVE A LATEX ALLERGY? ☐ YES ☐ NO TB/PPD TEST GIVEN (OR INTENDED TO BE GIVEN BEFORE BIOLOGIC STARTED)? ☐ YES ☐ NO (PLEASE send lab result)

PPRESCRIPTION INFORMATION

			QUQNTITY	REFILLS
☐ CIMZIA	☐ 200X2 PREFILLED SYRINGE ☐ 200X2 LYO POWDER	☐ STARTER KIT: INJECT 400mg SUBCUTANEOUSLY AT WEEKS 0, 2 AND 4 MAINTENANCE: ☐ INJECT 400mg SubQ ONCE EVERY 4 WEEKS OR ☐ INJECT 200mg SubQ ONCE EVERY 2 WEEKS	1 KIT 4 WEEK SUPPLY	NONE __________
☐ COSENTYX	300mg (2X150) ☐ PEN ☐ PFS 150mg ☐ PEN ☐ PFS	LOAD: INJECT ☐ 300mg OR ☐ 150mg SUBCUTANEOUSLY WEEK 0, 1, 2, 3, 4 MAINTENANCE: INJECT ☐ 300mg OR ☐ 150mg SUBCUTANEOUSLY EVERY 4 WEEKS	5 WEEK SUPPLY 4 WEEK SUPPLY	NONE __________
☐ ENBREL	50mg ☐ SURECLICK ☐ PFS ☐ MINI 25mg ☐ VIAL ☐ PFS	INJECT 50mg SUBCUTANEOUSLY ONCE A WEEK INJECT 25mg SUBCUTANEOUSLY TWICE A WEEK 72-96 HOURS APART	4 WEEK SUPPLY	__________
☐ HUMIRA CITRATE FREE	☐ UVEITIS STARTER KIT ☐ 40mg PEN ☐ 40mg PREFILLED SYRINGE	INJECT 80mg (1 PEN) ON DAY 1, THEN 40mg ON DAY 8, THEN 40mg EVERY OTHER WEEK ☐ INJECT 40mg SUBCUTANEOUSLY EVERY OTHER WEEK ☐ INJECT 40mg SUBCUTANEOUSLY ONCE A WEEK	LOADING DOSE 4 WEEK SUPPLY	NONE __________
☐ HUMIRA	☐ UVEITIS STARTER KIT ☐ 40mg PEN ☐ 40mg PREFILLED SRINGE	INJECT 2-40mg (80mg) ON DAY 1, THEN 40mg ON DAY 8, THEN 40mg EVERY OTHER WEEK ☐ INJECT 40mg SUBCUTANEOUSLY EVERY OTHER WEEK ☐ INJECT 40mg SUBCUTANEOUSLY ONCE A WEEK	LOADING DOSE 4 WEEK SUPPLY	NONE __________
☐ KEVZARA	200mg ☐ PEN ☐ PFS 150mg ☐ PEN ☐ PFS	INJECT 200mg SUBCUTANEOUSLY EVERY 2 WEEK INJECT 150mg SUBCUTANEOUSLY ONCE EVERY WEEK	4 WEEK SUPPLY	__________
☐ ORENCIA	125mg ☐ CLICKJECT ☐ PFS ☐ 250mg VIAL	INJECT 125mg SUBCUTANEOUSLY ONCE A WEEK INFUSE ___________ mg AT ______________________________	4 WEEK SUPPLY	__________
☐ OTEZLA	☐ STARTER PACK ☐ 30mg TABLETS	☐ TITRATE: TAKE 1 TABLETS ON DAY 1 THEN TWICE DAILY AS DIRECTED OR DATE PROVIDED ______________________________________ ☐ MAINTENANCE: TAKE 1 TABLET BY MOUTH TWICE DAILY ☐ BRIDGE RX: TAKE 1 TABLET BY MOUTH TWICE DAILY; DISPENSED BY OSP	1 STARTER PACK 60 28	NONE __________ 12
☐ STELARA	45mg PREFILLED SYRINGE	☐ STARTER: INJECT 45mg SUBCUTANEOUSLY ON WEEK 0 ☐ MAINTENANCE: INJECT 45mg SUBCUTANEOUSLY ON WEEK 4 AND THEN EVERY 12 WEEKS	1 1	NONE __________
☐ XELIANZ	☐ 5mG TABLETS ☐ 11mg XR TABLETS	TAKE 1 TABLET BY MOUTH TWICE DAILY TAKE 1 TABLET BY MOUTH ONCE DAILY	60 30	__________ __________
☐ OTHER				

By signing this form and utilizing our services, you are authorizing TODT HILL PHARMACY and its employees to serve as your authorization designated agent in dealing with medical and prescription insurance companies

PRESCRIBER'S SIGNATURE (no stamp) SUBSTITUTION PERMITTED ____ DATE ____

PRESCRIBER'S SIGNATURE (no stamp) DISPENSE AS WRITTEN ____ DATE ____