

Rheumatology (drugs A-E)

(Actemra®, Cimzia®, Cosentyx®, Enbrel®)



toll-free phone 855.611.3399
toll-free fax 855.423.8300

Patient Information

Patient name: _____ DOB: _____
Sex: ☐ Female ☐ Male SSN: _____
Language: _____ Wt: _____ ☐kg ☐lbs Ht: _____ ☐cm ☐in
Address: _____
Apt/Suite: _____ City: _____ State: _____ Zip: _____
Phone: _____ Alternate: _____
Caregiver name: _____ Relation: _____
Local pharmacy: _____ Phone: _____
Insurance plan: _____ Plan ID: _____

Please fax a copy of front and back of the insurance card(s).

Prescriber + Shipping Information

Prescriber name: _____
NPI: _____
Address: _____
Apt/Suite: _____ City: _____ State: _____ Zip: _____
Contact: _____
Phone: _____ Alternate: _____
Fax: _____
Email: _____
If shipping to prescriber: ☐ First Fill ☐ Always ☐ Never

Clinical Information (Please fax all pertinent clinical and lab information)

Diagnosis: ☐ M06.9 (Rheumatoid Arthritis) ☐ M08.0 (Juvenile Idiopathic Arthritis) ☐ L40.59 (Psoriatic Arthritis)
☐ L40.54 (Psoriatic Juvenile Arthritis) ☐ M45.9 (Ankylosing Spondylitis) ☐ _____

Diagnosis Date: _____ TB test: ☐ Yes ☐ No Negative Test Date: _____

Prior Therapy <input type="checkbox"/> Yes <input type="checkbox"/> No	Reason for Discontinuation of Therapy	Approximate Start Date	Approximate End Date
_____	_____	_____	_____
_____	_____	_____	_____

Comorbidities: _____
Concomitant Medications: _____
Allergies: ☐ NKDA ☐ Other: _____

Prescription

Quantity

Refill

<input type="checkbox"/> Actemra® (tocilizumab)	<input type="checkbox"/> Inject 162 mg subcut every week <input type="checkbox"/> Inject 162 mg subcut every other week <input type="checkbox"/> _____	<input type="checkbox"/> 4 x 162 mg/0.9mL <input type="checkbox"/> 2 x 162 mg/0.9mL <input type="checkbox"/> _____	<input type="checkbox"/> PFS <input type="checkbox"/> Vials	_____
<input type="checkbox"/> Cimzia® (certolizumab)	<input type="checkbox"/> Inject 400 mg subcut at weeks 0, 2 and 4 <input type="checkbox"/> Inject 200 mg subcut every 2 weeks <input type="checkbox"/> Inject 400 mg subcut every 4 weeks	<input type="checkbox"/> 6 x 200 mg/mL <input type="checkbox"/> 2 x 200 mg/mL	<input type="checkbox"/> PFS <input type="checkbox"/> Vials	0
<input type="checkbox"/> Cosentyx® (secukinumab)	Inject 150 mg subcut once weekly at weeks 0, 1, 2 and 3 Inject 300 mg subcut once weekly at weeks 0, 1, 2 and 3 <input type="checkbox"/> Inject 150 mg subcut on week 4 and every 4 weeks thereafter <input type="checkbox"/> Inject 300 mg subcut on week 4 and every 4 weeks thereafter	<input type="checkbox"/> 4 x 150 mg/mL <input type="checkbox"/> 8 X 150 mg/mL <input type="checkbox"/> 1 x 150 mg/mL <input type="checkbox"/> 2 x 150 mg/mL	<input type="checkbox"/> Sensoready® Pen <input type="checkbox"/> PFS <input type="checkbox"/> Sensoready® Pen <input type="checkbox"/> PFS	0
<input type="checkbox"/> Enbrel® (etanercept)	<input type="checkbox"/> Inject 50 mg subcut every week <input type="checkbox"/> Inject _____ mg (0.8 mg/kg x _____ kg) subcut every week	<input type="checkbox"/> 4 x 50 mg/mL <input type="checkbox"/> _____ x 25 mg/mL	<input type="checkbox"/> SureClick® Autoinjector <input type="checkbox"/> PFS <input type="checkbox"/> 50mg/ml Mini Cartridge	_____

§ Humira®, Kevzara®, Orencia®, Otezla® are available on the Rheumatology Enrollment Form F-R §

§ Simponi®, Simponi Aria®, Stelara®, Xeljanz®, Xeljanz® XR are available on the Rheumatology Enrollment Form S-Z §

Injection Training Provided by: ☐ Prescriber's Office ☐ Pharmacy ☐ Other: _____

Per state-specific law, prescriptions will be dispensed as generic, if applicable, unless notated otherwise: _____

Stamp signature not allowed, physician signature required.

Prescriber's Signature: _____ Date: _____

I authorize Thrifty White Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time by providing written notice to Thrifty White Specialty Pharmacy.

Confidentiality Statement: This message is intended only for the individual or entity to which it is addressed. It may contain information which may be proprietary and confidential. It may also contain privileged, confidential information which is exempt from disclosure under applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA). If you are not the intended recipient, please note that you are strictly prohibited from disseminating or distributing this information (other than to the intended recipient) or copying this information. If you received this communication in error, please notify the sender immediately by calling 855-611-3399 or by emailing specialty@thriftywhite.com to obtain instructions as to the proper destruction of the transmitted material. Thank you.

www.thriftywhite.com

Updated on 08/17

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