

# Rheumatology (S-Z)

(Simponi®, Simponi Aria®, Stelara®, Xeljanz®, Xeljanz® XR)



toll-free phone 855.611.3399  
toll-free fax 855.423.8300

Patient Information	Prescriber + Shipping Information
Patient name: _____ DOB: _____	Prescriber name: _____
Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male SSN: _____	NPI: _____
Language: _____ Wt: _____ <input type="checkbox"/> kg <input type="checkbox"/> lbs Ht: _____ <input type="checkbox"/> cm <input type="checkbox"/> in	Address: _____
Address: _____	Apt/Suite: _____ City: _____ State: _____ Zip: _____
Apt/Suite: _____ City: _____ State: _____ Zip: _____	Contact: _____
Phone: _____ Alternate: _____	Phone: _____ Alternate: _____
Caregiver name: _____ Relation: _____	Fax: _____
Local pharmacy: _____ Phone: _____	Email: _____
Insurance plan: _____ Plan ID: _____	If shipping to prescriber: <input type="checkbox"/> First Fill <input type="checkbox"/> Always <input type="checkbox"/> Never

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

Clinical Information (Please fax all pertinent clinical and lab information)			
<b>Diagnosis:</b> <input type="checkbox"/> M06.9 (Rheumatoid Arthritis) <input type="checkbox"/> M08.0 (Juvenile Idiopathic Arthritis) <input type="checkbox"/> L40.59 (Psoriatic Arthritis) <input type="checkbox"/> L40.54 (Psoriatic Juvenile Arthritis) <input type="checkbox"/> M45.9 (Ankylosing Spondylitis) <input type="checkbox"/> _____			
Diagnosis Date: _____ TB test: <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> NKDA <input type="checkbox"/> Other: _____			

Prescription	Quantity	Refill
<b>§ Actemra®, Cimzia®, Cosentyx®, Enbrel® are available on the Rheumatology Enrollment Form A-E §</b> <b>§ Humira®, Kevzara®, Orencia®, Otezla® are available on the Rheumatology Enrollment Form F-R §</b>		
<input type="checkbox"/> <b>Simponi®</b> (golimumab)	<input type="checkbox"/> Inject 50 mg subcut once a month <input type="checkbox"/> 1 x 50 mg/0.5mL	<input type="checkbox"/> SmartJect® Autoinjector <input type="checkbox"/> PFS _____
<input type="checkbox"/> <b>Simponi Aria®</b> (golimumab)	<input type="checkbox"/> Infuse _____ mg (2 mg/kg x _____ kg) over 30 minutes at weeks 0 <input type="checkbox"/> _____ x 50 mg/4ml	Vials 0
	<input type="checkbox"/> Infuse _____ mg (2 mg/kg x _____ kg) over 30 minutes at week 4 and every 8 weeks thereafter <input type="checkbox"/> _____ x 50 mg/4ml	Vials _____
<input type="checkbox"/> <b>Stelara®</b> (ustekinumab)	<input type="checkbox"/> Inject 45 mg subcut on Day 1 (≤100 kg) <input type="checkbox"/> Inject 90 mg subcut on Day 1 (>100 kg) <input type="checkbox"/> 1 x 45 mg/0.5mL <input type="checkbox"/> 1 x 90 mg/mL	PFS 0
	<input type="checkbox"/> Inject 45 mg subcut on Day 29 and every 12 weeks thereafter (≤100 kg) <input type="checkbox"/> Inject 90 mg subcut on Day 29 and every 12 weeks thereafter (>100 kg) <input type="checkbox"/> 1 x 45 mg/0.5mL <input type="checkbox"/> 1 x 90 mg/mL	PFS _____
Patient eligible for self-administration: <input type="checkbox"/> Yes <input type="checkbox"/> No _____		
<input type="checkbox"/> <b>Xeljanz®</b> (tofacitinib)	<input type="checkbox"/> Take 5 mg by mouth twice daily <input type="checkbox"/> _____ <input type="checkbox"/> 60 x 5 mg tablets <input type="checkbox"/> _____	_____
<input type="checkbox"/> <b>Xeljanz® XR</b> (tofacitinib)	<input type="checkbox"/> Take 11 mg by mouth once daily <input type="checkbox"/> 30 x 11 mg tablets	_____

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

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

Prescriber's Signature: _____	Date: _____
<small>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.</small>	

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www.thriftywhite.com

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