Rheumatology (S-Z)

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

Employee Owned Thrifty White PHARMACY Specialty Services
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 ☐ Yes ☐ No	Reason for Discontinuation of Therapy	Approximate Start Date	Approximate End Date

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

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

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.

Reset Form