



2100 New Bern Ave,
Raleigh, NC 27610
P. 855-326-9112 / F. 855-326-9114

Rheumatology (A-K)

Prescriber information	
Prescriber:	NPI:
Supervising physician:	NPI:
Address:	
Phone:	Fax:
Office contact:	

Patient information			
Name:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	DOB:	SSN:
Address:	City:	State:	Zip:
Phone:	Emergency contact:	Phone:	
Weight:	Height:	Allergies:	
Primary language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other:		Needs interpreter: <input type="checkbox"/> Yes <input type="checkbox"/> No	

Please include copies of the patient's insurance card or local pharmacy information.

Medical information		
Primary diagnosis:	ICD-10:	Date of diagnosis:
Previous therapies:	Duration:	Outcome:

Prescription information				
Drug	Strength	Directions	Qty	Refills
<input type="checkbox"/> Actemra® (tocilizumab)	<input type="checkbox"/> 162 mg prefilled syringe	Inject 162 mg subcutaneously: <input type="checkbox"/> Every other week <input type="checkbox"/> Once per week <input type="checkbox"/> Other: _____	30 days 90 days	
<input type="checkbox"/> Cimzia® (certolizumab pegol)	<input type="checkbox"/> 200 mg prefilled syringe	Initial dose: <input type="checkbox"/> 400 mg subcutaneously at weeks 0, 2, and 4 Maintenance: <input type="checkbox"/> 200 mg subcutaneously once every 14 days <input type="checkbox"/> 400 mg subcutaneously once every 28 days <input type="checkbox"/> Other: _____	30 days 90 days	
<input type="checkbox"/> Enbrel® (etanercept)	<input type="checkbox"/> 25 mg prefilled syringe <input type="checkbox"/> 50 mg prefilled syringe <input type="checkbox"/> 50 mg SureClick™ <input type="checkbox"/> 50 mg Mini®	<input type="checkbox"/> Inject 25 mg subcutaneously once weekly <input type="checkbox"/> Inject 50 mg subcutaneously once weekly <input type="checkbox"/> Other: _____	30 days 90 days	
<input type="checkbox"/> Humira® (adalimumab)	<input type="checkbox"/> 40 mg/0.8 ml PFS <input type="checkbox"/> 40 mg/0.8ml PENS <input type="checkbox"/> 40 mg/0.4 ml CF PEN	<input type="checkbox"/> Inject 40 mg subcutaneously every 14 days <input type="checkbox"/> Inject 40 mg subcutaneously once weekly	30 days 90 days	
<input type="checkbox"/> Kevzara®	<input type="checkbox"/> 150 mg/1.14 ml PFS <input type="checkbox"/> 200 mg/1.14 ml PFS	<input type="checkbox"/> Inject 150 mg subcutaneously every 14 days <input type="checkbox"/> Inject 200 mg subcutaneously every 14 days	30 days 90 days	
<input type="checkbox"/> Other	_____	_____	30 days 90 days	
<input type="checkbox"/> Prescriber authorizes dispensing of ancillary kits and supplies as necessary/applicable		As needed for administration	30 days 90 days	

By signing below I authorize Josefs Pharmacy and its representatives to serve as a prior authorization designated agent in dealing with medical and prescription insurance companies.

Stamp signature not allowed, physician attests this is his/her legal signature.

PHYSICIAN SIGNATURE REQUIRED

Dispense as Written / Brand Medically Necessary

Substitution allowed

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