JOSEFS PHARMACY

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: ☐ M ☐ F	DOB:	SSN:
Address:	City:	State:	Zip:
Phone:	Emergency contact:	Phone:	
Weight: Height:	Allergies:		
Primary language: ☐ English ☐ Spanish ☐ Other:	Needs interpreter: ☐ Yes ☐ 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
☐ Actemra® (tocilizumab)	☐ 162 mg prefilled syringe	Inject 162 mg subcutaneously: ☐ Every other week ☐ Once per week ☐ Other _____	☐ 30 days ☐ 90 days	
☐ Cimzia® (certolizumab pegol) ☐	☐ 200 mg prefilled syringe	Initial dose: ☐ 400 mg subcutaneously at weeks 0, 2, and 4 Maintenance: ☐ 200 mg subcutaneously once every 14 days ☐ 400 mg subcutaneously once every 28 days ☐ Other:_____	☐ 30 days ☐ 90 days	
☐ Enbrel® (etanercept)	☐ 25 mg prefilled syringe ☐ 50 mg prefilled syringe ☐ 50 mg SureClick™ ☐ 50 mg Mini®	☐ Inject 25 mg subcutaneously once weekly ☐ Inject 50 mg subcutaneously once weekly ☐ Other:_____	☐ 30 days ☐ 90 days	
☐ Humira® (adalimumab)	☐ 40 mg/0.8 ml PFS ☐ 40 mg/0.8ml PENS ☐ 40 mg/0.4 ml CF PEN	☐ Inject 40 mg subcutaneously every 14 days ☐ Inject 40 mg subcutaneously once weekly	☐ 30 days ☐ 90 days	
☐ Kevzara®	☐ 150 mg/1.14 ml PFS ☐ 200 mg/1.14 ml PFS	☐ Inject 150 mg subcutaneously every 14 days ☐ Inject 200 mg subcutaneously every 14 days	☐ 30 days ☐ 90 days	
☐ Other	_____	_____	☐ 30 days ☐ 90 days	
☐ 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**