JOSEFS PHARMACY

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

Rheumatology (L-Z)

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**
☐ Olumiant® 2 mg (baricitinib)	Take one tablet by mouth once daily		☐ 30 days ☐ 90 days	
☐ Orencia® (abatacept)	☐ 125 mg/ml PFS ☐ 125 mg/ml ClickJect™	Initial dose: ☐ 400 mg subcutaneously at weeks 0, 2, and 4 Maintenance: ☐ 200 mg subcutaneously every 14 days ☐ Other:_____	☐ 30 days ☐ 90 days	
☐ Remicade® (infliximab)	100 mg/vial	Dose: _____mg/kg Total dose: _____ mg Directions: _____	☐ 30 days ☐ 90 days	
☐ Rinvoq™ 15 mg (upadacitinib)	☐ Take one tablet by mouth once daily		☐ 30 days ☐ 90 days	
☐ Simponi® (golimumab)	☐ 50 mg/0.5 ml SmartJect™ ☐ 50 mg/0.5 ml PFS	Inject 50 mg subcutaneously once per month	☐ 30 days ☐ 90 days	
☐ Simponi Aria® (golimumab)	50 mg/4 ml vial	Dose: _____mg/kg Total dose: _____ mg Directions: _____	☐ 30 days ☐ 90 days	
☐ Xeljanz® 5 mg (tofacitinib)	Take one tablet by mouth two times daily		☐ 30 days ☐ 90 days	
☐ Xeljanz® XR (tofacitinib)	Take one tablet by mouth one time daily		☐ 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**