



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