

ADVOCATE PHARMACY

Phone: 215-362-2479

535 South Broad Street Lansdale PA 19446

Rheumatoid Arthritis Prescription & Pharmacy Intake Form

Provider Representative

Phone

Date Needed

Ship to Specialty Care Center Patient's Home
 Prescriber's Office Other

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Male Female
Address: _____
City: _____ State: _____ Zip Code: _____
Phone # (Daytime): _____ Phone # (Evening): _____
E-mail Address: _____ Case Manager: _____
Insurance Provider (Please include copy of front and back of card): _____
ID#: _____ Policy/Group #: _____ Phone #: _____
Name of Insured: _____ Employer: _____
Relationship to Patient: Self Other: _____ Patient is Eligible for Medicare
Prescription Card: Yes No Carrier: _____ Policy/Group #: _____
Will there be access to anaphylactic medications and oxygen at the administration site? _____

CLINICAL ASSESSMENT

Patient is New to Therapy
 Patient is Currently on Therapy
(Start Date: _____)
 Physician Provides injection Training
Injection/Infusion Date: _____

Primary ICD-9 Code and Condition: _____

Other ICD-9/ Conditions: _____

Joints Affected: _____

Number of Tender Joints: _____

Number of Swollen Joints: _____

Current Weight: _____ Date: _____

New Therapy Induction | Stop Date: _____
 Therapy Change | Stop Date: _____
 Therapy Continuation | Stop Date: _____
Weeks Completed 0 2 4 6

ESR & Date: _____

CRP & Date: _____

TB Results & Date: _____

Allergies: _____

Medication	Dose/Directions/Freq	Qty	Refills
Actemra® (tocilizumab) <input type="checkbox"/> 80 mg/4 mL Vial <input type="checkbox"/> 200 mg/10 mL Vial <input type="checkbox"/> 400 mg/20 mL Vial			
Cimzia® (certolizumab pegol) <input type="checkbox"/> 2x200 mg kit <input type="checkbox"/> Syringe <input type="checkbox"/> Vial			
Enbrel® (etanercept) <input type="checkbox"/> 25 mg Syringe <input type="checkbox"/> 25 mg Vial <input type="checkbox"/> 50 mg Syringe <input type="checkbox"/> 50 mg Sure Click" Pen			
Humira® (adalimumab) <input type="checkbox"/> 20 mg Syringe <input type="checkbox"/> 40 mg Syringe <input type="checkbox"/> 40mgPen			
Kineret® (anakinra) <input type="checkbox"/> 100 mg Syringe			
Orencia® (abatacept) <input type="checkbox"/> (4) 125 mg Prefilled Syringe <input type="checkbox"/> 250 mg Vial			
Remicade® (infliximab) <input type="checkbox"/> 100 mg Vial			
Rituxan® (rituximab) <input type="checkbox"/> 100 mg Vial <input type="checkbox"/> 500 mg Vial			
Simponi® (golimumab) <input type="checkbox"/> 50 mg Syringe <input type="checkbox"/> 50 mg Smartject			
Methodretaxate - Can only be ordered as combined therapy with one of above drugs			
<input type="checkbox"/> 2.5 mg Tablet			
<input type="checkbox"/> Other _____			

PRESCRIBER INFORMATION

Prescriber's Name: _____ Practice/Facility Name: _____
Address: _____ Office Contact: _____
City: _____ State: _____ Zip Code: _____
Phone #: _____ Fax: _____ Best Time to Call: _____
State Licenses #: _____ DEA #: _____ NPI#: _____ Medicaid UPIN #: _____
In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary," or your state specific required language to prohibit substitution: _____
I certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge.
Prescriber's Signature Required: _____ Date: _____

CONFIDENTIAL HEALTH INFORMATION: Healthcare information is personal information related to a person's healthcare, it bring-faxed to you after appropriate authorization or under circumstances that don't require authorization. You are obligated to maintain it in a safe, secure and confidential manner. Re-disclosure of this information is prohibited unless permitted by law or appropriate customer/patient authorization is obtained. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state laws.

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