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 lCD-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) ☐ 80 mg/4 mL Vial ☐ 200 mg/10 mL Vial ☐ 400 mg/20 mL Vial			
Cimzia® (certolizumab pegol) ☐ 2x200 mg kit ☐ Syringe ☐ Vial			
Enbrel® (etanercept) ☐ 25 mg Syringe ☐ 25 mg Vial ☐ 50 mg Syringe ☐ 50 mg Sure Click" Pen			
Humira® (adalimumab) ☐ 20 mg Syringe ☐ 40 mg Syringe ☐ 40mgPen			
Kineret® (anakinra) ☐ 100 mg Syringe			
Orencia® (abatacept) ☐ (4) 125 mg Prefilled Syringe ☐ 250 mg Vial			
Remicade® (infliximab) ☐ 100 mg Vial			
Rituxan® (rituximab) ☐ 100 mg Vial ☐ 500 mg Vial			
Simponi® (golimumab) ☐ 50 mg Syringe ☐ 50 mg Smartject			
Methotrexate - Can only be ordered as combined therapy with one of above drugs			
☐ 2.5 mg Tablet			
☐ 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: _____