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FountainRx

Rheumatology

Please fax patient demographics with prescription order form to:

Toll-Free 1-844-621-5199

Patient Information:

Name:______________________________
Address:______________________________
City:__________________State:____Zip:__________
Phone:______________Alt Phone:______________
Email:______________________________
DOB:__________Height:__________Weight:__________
Gender: M F Caregiver:______________________

Prescriber Information:

Name:______________________________
Address:______________________________
City:__________________State:_____Zip:__________
Phone:__________________Fax:______________
NPI:__________________DEA:______________
Tax ID:______________________________
Office Contact:__________________Phone:______________

CLINICAL INFORMATION: Diagnosis:
☐ **M06.9 Rheumatoid Arthritis** ☐ **L40.50 Arthropathic psoriasis, unspecified**
☐ **M45.9 Ankylosing Spondylitis** ☐ **M32.10 Systemic Lupus Erythematosus** ☐ **Other (ICD-10 Code):**______________________

Drug Allergies:____

Latex Allergy? Yes No **TB/PPD?** Positive Negative (Please send copy of results)

Prior Failed Medications:
☐ **Methotrexate** Length of Treatment:__________Reason for Discontinuing:__________
☐ **Other:**__________Length of Treatment:__________Reason for Discontinuing:__________
☐ **Other:**__________Length of Treatment:__________Reason for Discontinuing:__________

PLEASE FAX COPIES: ☐ **Medical Card (Front and Back)** ☐ **Prescription Card (Front and Back)** ☐ **Clinical Notes**

Medication	Dosage and Strength	Directions	Quantity	Refills
☐ Actemra®	☐ 162mg/0.9ml Prefilled Syringe	☐ Inject 162mg SC every other week (<220 lbs.) ☐ Inject 162mg SC every week (>220 lbs.)	2 4	
☐ Cimzia®	☐ Prefilled Syringe Starter Kit ☐ 200mg/ml Prefilled Syringe	☐ **Starter Kit**: Inject 400mg SC on day 1, day 14, and day 28 ☐ **Maintenance Dose:** Inject 200mg SC every other week ☐ **Maintenance Dose:** Inject 400mg SC every 4 weeks	6 2 2	None
☐ Cosentyx®	☐ 150mg/ml Sensoready® Pen ☐ 150mg/ml Prefilled Syringe ☐ 150mg Lyophilized Powder Vial	☐ **Induction Dose:** Inject 150mg SC at weeks 0, 1, 2, 3, and 4 ☐ **Induction Dose:** Inject 300mg SC at weeks 0, 1, 2, 3, and 4 ☐ **Maintenance Dose:** Inject 150mg SC every four (4) weeks ☐ **Maintenance Dose:** Inject 300mg SC every four (4) weeks	5 10 1 2	None None
☐ Enbrel®	☐ 50mg/ml Sureclick® Autoinjector ☐ 50mg/ml Enbrel Mini™ Prefilled Cartridge ☐ 50mg/ml Prefilled Syringe ☐ 25mg/0.5ml Prefilled Syringe ☐ 25mg/ml Vial	☐ Inject 50mg SC once a week ☐ Inject 25mg SC twice a week (72 to 96 hours apart) ☐ Other:______________________	4 8	
☐ Humira®	☐ 40mg/0.8ml Pen ☐ 40mg/0.8ml Prefilled Syringe ☐ 40mg/0.4ml Pen ☐ 40mg/0.4ml Prefilled Syringe	☐ Inject 40mg SC every other week ☐ Inject 40mg SC once a week ☐ Patient has signed Humira® Complete Form	2 4	
☐ Kevzara®	☐ 150mg/1.14ml Prefilled Syringe ☐ 200mg/1.14ml Prefilled Syringe ☐ 150mg/1.14ml Autoinjector ☐ 200mg/1.14ml Autoinjector	☐ Inject 150mg SC every 2 weeks ☐ Inject 200mg SC every 2 weeks	2 2	
☐ Orencia®	☐ 125mg/ml ClickJect™ Autoinjector ☐ 125mg/ml Prefilled Syringe	☐ **Maintenance Dose:** Inject 125mg SC once a week (110lbs or more)	4	
☐ Otezla®	☐ Starter Pack (Titration) ☐ 30mg Tablets	☐ **Starter Pack:** Take one (1) tablet in the morning on day 1, then take one (1) tablet in the morning and one (1) tablet in the evening as directed on the starter pack ☐ **Maintenance:** Take one (1) 30mg tablet by mouth twice daily	55 60	None ______
☐ Rinvoq™	☐ 15mg ER Tablet	☐ Take one (1) 15mg tablet by mouth once daily	30	
☐ Simponi®	☐ 50mg/0.5ml Smartject Autoinjector ☐ 50mg/0.5ml Prefilled Syringe	☐ Inject 50mg once a month	1	
☐ Stelara®	☐ 45mg/0.5ml Prefilled Syringe (for <220lbs.) ☐ 90mg/1ml Prefilled Syringe (for > 220lbs.)	☐ **Initial Dose:** Inject one (1) prefilled syringe SC at 0 and 4 weeks ☐ **Maintenance: Dose** Inject one (1) prefilled syringe SC every 12 weeks	2 1	None ______
☐ Taltz®	☐ 80mg/ml Prefilled Autoinjector ☐ 80mg/ml Prefilled Syringe	☐ **Initial Dose:** Inject 160mg SC at week 0 ☐ **Maintenance Dose:** Inject 80mg SC every 4 weeks	2 1	None ______
☐ Xeljanz®	☐ 5mg Tablet	☐ Take one (1) 5mg tablet by mouth twice a day	60	
☐ Xeljanz®XR	☐ 11mg Tablet	☐ Take one (1) 11mg tablet by mouth once a day	30	
☐ Other				

By signing this form and utilizing our services, you are authorizing FountainRx and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies and patient assistance programs. My signature certifies that the person named on this form is my patient, the information provided on this application, to the best of my knowledge, is complete and accurate and the therapy identified is medically necessary.

Physician Signature:______________________________ **Date:**______________________