



Rheumatology

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: _____
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CLINICAL INFORMATION: Diagnosis:

<input type="checkbox"/> M06.9 Rheumatoid Arthritis	<input type="checkbox"/> L40.50 Arthropathic psoriasis, unspecified
<input type="checkbox"/> M45.9 Ankylosing Spondylitis	<input type="checkbox"/> 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:

<input type="checkbox"/> Methotrexate	Length of Treatment: _____	Reason for Discontinuing: _____
<input type="checkbox"/> Other: _____	Length of Treatment: _____	Reason for Discontinuing: _____
<input type="checkbox"/> Other: _____	Length of Treatment: _____	Reason for Discontinuing: _____

PLEASE FAX COPIES:

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