RELIANT HEALTHCARE

Rheumatology
ORDER FORM

Phone: (877) 354-2688
Fax: (844) 635-5250

PATIENT INFORMATION

Name:
Address:
City: **State:** **ZIP:**
Phone: **Alt Phone:**
Email: **Caregiver:**
DOB: **Ht:** **Wt:** **Gender:** ☐ M ☐ F

PRESCRIBER INFORMATION

Name:
Address:
City: **State:** **ZIP:**
Phone: **Fax:**
NPI: **DEA:** **Tax ID:**
Office Contact: **Phone:**

CLINICAL INFORMATION

Diagnosis (ICD-10): ☐ 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 Result: ☐ Positive ☐ Negative (please send copy of results) **Date:** **Result:**

Prior Failed Medications: ☐ Methotrexate **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 ☐ SHIP TO HOME ☐ IN OFFICE	QTY	REFILLS
☐ **Actemra**	☐ 162mg/0.9mL Prefilled Syringe ☐ 162mg/0.9mL ACTPen	☐ Inject 162mg SC every other week (less than 220 lbs) ☐ Inject 162mg SC every week for 220 lbs or more, or based on clinical response if under 220 lbs	QS QS	
☐ **Adalimumab***	☐ 40mg/0.8mL ☐ Pen ☐ PFS ☐ 40mg/0.4mL ☐ Pen ☐ PFS ☐ DAW1 Product:	☐ Inject 40mg SC every other week ☐ Inject 40mg SC once a week ☐ Inject 80mg SC every other week	QS QS QS	
☐ **Bimzelx**	☐ 160mg/mL Prefilled Autoinjector ☐ 160mg/mL Prefilled Syringe	☐ Inject 160mg SC every 4 weeks	QS	
☐ **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	QS QS QS	None
☐ **Cosentyx**	☐ 300mg/2mL UnoReady Pen ☐ 150mg/mL Sensoready Pen ☐ 150mg/mL Prefilled Syringe	☐ **Induction Dose:** Inject 150mg SC at weeks 0, 1, 2, and 3 ☐ **Induction Dose:** Inject 300mg SC at weeks 0, 1, 2, and 3 ☐ **Maintenance Dose:** Inject 150mg SC every four (4) weeks beginning on week 4 ☐ **Maintenance Dose:** Inject 300mg SC every four (4) weeks beginning on week 4	QS QS QS QS	None None
☐ **Enbrel**	☐ 50mg/mL ☐ SureClick ☐ PFS ☐ 50mg/mL Enbrel Mini Cartridge ☐ 25mg/0.5mL ☐ PFS ☐ Vial	☐ Inject 50mg SC once a week ☐ Inject 25mg SC twice a week (72 to 96 hours apart) ☐ Other:	QS QS	
☐ **Kevzara**	☐ 150mg/1.14mL ☐ PFS ☐ Pen ☐ 200mg/1.14mL ☐ PFS ☐ Pen	☐ Inject 150mg SC every 2 weeks ☐ Inject 200mg SC every 2 weeks	QS QS	
☐ **Olumiant**	☐ 2mg Tablet	☐ Take 1 tablet (2mg) PO once daily	QS	
☐ **Orencia**	☐ 125mg/mL ClickJect Autoinjector ☐ 125mg/mL Prefilled Syringe	☐ **Maintenance Dose:** Inject 125mg SC once a week (100 lbs or more)	QS	
☐ **Otezla**	☐ Starter Pack (Titration) ☐ 30mg Tablet ☐ 75mg XR Tablet	☐ **Starter Pack:** Take one (1) tablet PO in the AM on day 1, then take one (1) tablet PO in the AM and one (1) tablet PO in the PM as directed on the pack ☐ **Maintenance:** Take one (1) 30mg tablet PO twice daily ☐ **Maintenance (XR):** Take one (1) 75mg XR tablet PO once daily	QS QS QS	None
☐ **Rinvoq**	☐ 15mg ER Tablet	☐ Take one (1) 15mg tablet PO once daily	QS	
☐ **Simponi**	☐ 50mg/0.5mL SmartJect Autoinjector ☐ 50mg/0.5mL Prefilled Syringe	☐ Inject 50mg SC once a month	QS	
☐ **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	QS QS	None
☐ **Ustekinumab***	☐ 45mg/0.5mL PFS (220 lbs or less) ☐ 90mg/mL PFS (over 220 lbs) ☐ DAW1 Product:	☐ **Initial Dose:** Inject one (1) prefilled syringe SC at week 0 ☐ **Maintenance Dose:** Inject one (1) prefilled syringe SC every 12 weeks beginning on week 4	QS QS	None
☐ **Xeljanz** ☐ **Xeljanz XR**	☐ 5mg Tablet ☐ 11mg XR Tablet	☐ Take one (1) 5mg tablet PO twice a day ☐ Take one (1) 11mg XR tablet PO once a day	QS QS	
☐ **Other**		Directions:		

***Pharmacy may select a biosimilar based on payor guidelines unless DAW1 is selected.**

By signing, I authorize Reliant Healthcare and its employees to act as my prior authorization designated agent with medical and prescription insurers and patient assistance programs, and to substitute an approved biosimilar if required or allowed by insurance coverage. I certify that the person named is my patient, the information provided is complete and accurate to the best of my knowledge, and the therapy is medically necessary.

Physician Name (Print) Physician Signature Date