MILNER RUSHING SPECIALTY CARE

RHEUMATOID ARTHRITIS SPECIALTY CARE PROGRAM

Phone: **844-316-7850** • Fax: **844-673-2247**

KLOUDSCRIPT
Community Led Specialty Pharmacy Care

1 PATIENT INFORMATION:

Name: ______________________
Address: ______________________
City: ____________ State: ____ Zip: ________
Phone: ____________ Alt. Phone: ____________
Email: ______________________
DOB: ________ Gender: ❍ M ❍ F Caregiver: ________
Height: ______ Weight: ______ Allergies: ________

2 PRESCRIBER INFORMATION:

Name: ______________________
Address: ______________________
City: ____________ State: ____ Zip: ________
Phone: ____________ Fax: ____________
NPI: ____________ DEA: ____________
Tax I.D.: ______________________
Office Contact: ____________ Phone: ____________

3 STATEMENT OF MEDICAL NECESSITY: (Please Attach All Medical Documentation)

Date of Diagnosis: ______________
ICD-10: ______________
Other: ______________
TB Test: ❑ Positive ❑ Negative Date: ______

Patient also taking Methotrexate? ❑ Yes ❑ No
Serious or active infection present? ❑ Yes ❑ No
Hep B ruled out or treatment started? ❑ Yes ❑ No
Does patient have latex allergy? ❑ Yes ❑ No

If Prior Authorization is Denied:
❑ Automatically Draft Appeal for Review ❑ Send Preferred Formulary Alternatives

Prior Failed Treatments:	Indicate Drug Name and Length of Treatment:
❑ Azulfidine®	____________
❑ Biologics	____________
❑ Calcipotriene	____________
❑ Celebrex®	____________
❑ Corticosteroids	____________
❑ Indocin®	____________
❑ Methotrexate	____________
❑ Others	____________

4 PRESCRIPTION INFORMATION: (Please be sure to choose both induction and maintenance dose where applicable)

Medication	Dosage & Strength	Direction	QTY	Refills
❑ ACTEMRA®	❑ 162mg/0.9ml Prefilled Syringe	❑ Inject 162mg SC every other week (< 220 lbs) ❑ Inject 162mg SC every week (> 220 lbs)		
❑ CIMZIA®	❑ Prefilled Syringe Starter Kit ❑ 200mg/ml Prefilled Syringe ❑ 200mg Lyophilized Powder Vial	❑ **Induction Dose:** Inject 400mg SC on day 1, day 14 and day 28	6	0
		❑ **Maintenance:** Inject 400mg SC every 4 weeks ❑ **Maintenance:** Inject 200mg SC every other week	2	
❑ ENBREL®	❑ 50mg/ml Sureclick Autoinjector ❑ 50mg/ml Prefilled Syringe ❑ 25mg/ml Prefilled Syringe ❑ 25mg/ml Vial	❑ Inject 50mg SC once a week ❑ Inject 25mg SC twice a week (3-4 days apart) ❑ Other______________		
❑ HUMIRA®	❑ 40mg/0.8ml Pen ❑ 40mg/0.8ml Prefilled Syringe ❑ *Patient has signed HUMIRA Complete form*	❑ Inject 40mg SC every other week ❑ Inject 40mg SC once a week		
❑ ORENCIA®	❑ 250mg Lyophilized Powder Vial ❑ 125mg/ml ClickJect Autoinjector ❑ 125mg/ml Prefilled Syringe	❑ **Induction Dose:** Patient Weight < 132 lbs: 500mg; 132-220 lbs: 750mg; > 220 lbs: 1000mg administered IV, then inject 125mg SC within 24 hours		0
		❑ Inject 125mg SC once a week	4	
❑ OTEZLA® (for PsA)	❑ Starter Pack (Titration) ❑ 30mg Tablets	❑ **Starter Pack:** Take one tablet in the morning on day 1, then take one tablet in the morning and one tablet in the evening as directed on the starter pack	1	0
		❑ **Maintenance:** Take one 30mg tablet by mouth twice daily	60	
❑ SIMPONI®	❑ 50mg/0.5ml Smartject Autoinjector ❑ 50mg/0.5ml Prefilled Syringe	❑ Inject 50mg SC once a month	1	
❑ STELARA® (for PsA)	❑ 45mg/0.5ml Prefilled Syringe (for < 220 lbs) ❑ 90mg/1ml Prefilled Syringe (for > 220 lbs)	❑ **Induction Dose:** Inject 1 prefilled syringe SC on day 1	1	0
		❑ **Maintenance:** Inject 1 prefilled syringe SC on day 29, and every 12 weeks thereafter	1	
	❑ Yes or ❑ No: ***STELARA SELF-INJECTION:*** *Healthcare provider certifies that patient has been trained and is eligible for self-injection*			
❑ XELJANZ®	❑ 5mg Tablet	❑ Take one 5mg tablet by mouth twice a day	60	
❑ XELJANZ® XR	❑ 11mg Tablet	❑ Take one 11mg tablet once a day	30	
❑ __________	__________	__________		

5 INJECTION TRAINING:
❍ Pharmacist to Provide Training ❍ Patient Trained in MD Office ❍ Manufacturer Nurse Support

6 PRODUCT DELIVERY:
❍ Patient's Home ❍ Physician's Office ❍ Pharmacy to Coordinate

7 INSURANCE INFORMATION:
Please include front and back copies of pharmacy and medical card

8 PRESCRIBER SIGNATURE:
I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs.

Signature: ______________ Date: ________
Substitution Permitted

Signature: ______________ Date: ________
Dispense As Written

Prior authorization approval and insurance benefits will be determined by the payor based upon the patient's eligibility, medical necessity, and the terms of the patient's coverage, among other things. Participation in this program is not a guarantee of prior authorization or of payment.

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