VERBAL ORDER FORM
RHEUMATOLOGY

QuickRX SPECIALTY PHARMACY

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NPI# 1003148321 NCPDP# 3364471
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Today's Date _____
Date Needed _____

☐ Phone Order
Ship to Patient:
☐ Home ☐ Work
Ship to:
☐ Physician Office
☐ Nurse / Training
☐ QuickRX Pharmacy

Patient Name_____ Date of Birth_____ ☐ Male ☐ Female
Address_____ Apt #_____ City_____ State____ Zip_____
Telephone_____ Cell_____ SSN_____ Email_____
Allergies_____ Comorbidities_____
Current medications (including OTC) w/ dosage & direction (or fax medication) _____

Primary Insurance_____ ID#_____ Group #_____
Insured's Name_____ Employer_____
City_____ State_____ Phone_____

ICD-10 Diagnosis Code ☐ **L40.59** Psoriatic Arthritis ☐ **M32.10** SLE ☐ **M06.9** Rheumatoid Arthritis ☐ **M45.9** Ankylosing Spondylitis ☐ **M35.2** Behçet's Disease
☐ **M19.90** Osteoarthritis, unspecified site ☐ **M81.0** Age-related osteoporosis without current fracture ☐ Other _____
Previously treated for this condition? ☐ Yes ☐ No Medication(s) failed _____
Patient currently taking Methotrexate? ☐ Yes ☐ No For Humira/Enbrel: PPD (TB Test) Results_____ Date_____ Total Swollen Joints_____
Rheumatoid Factor Positive_____ For Forteo: T-Score_____ Date_____ Fracture History: Site_____ Date_____

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

☐ **HUMIRA® PEN** 40mg/0.8 mL ☐ **HUMIRA® PFS** 40mg/0.8 mL
☐ **HUMIRA® Citrate-Free PEN** 40mg/0.4 mL ☐ **HUMIRA® Citrate-Free PFS** 40mg/0.4 mL
SIG: ☐ Inject 40mg SQ every OTHER week | ☐ Inject 40mg SQ ONCE a week
QTY: _____ Refill: _____ ☐ If applicable, enroll patient in *Ambassador Program*

ENBREL® ☐ SureClick™ Autoinjector 50mg ☐ PFS 25mg ☐ PFS 50mg
☐ Multiuse Vial 25mg *(injection supplies included)* ☐ Enbrel Mini™/AutoTouch 50mg
SIG: ☐ 50mg once weekly ☐ 25mg twice weekly QTY: 4 week supply Refill: _____
☐ If applicable, enroll patient in *ENBREL Support™*

CIMZIA® ☐ 200mg/1ml PFS ☐ PFS Starter Kit ☐ If applicable, enroll patient in *CIMplicity®*
☐ Initial Dose: Inject 400mg SQ on day 1, at week 2 & at week 4
☐ Maintenance Dose: Inject 200mg SQ every OTHER week QTY: _____ Refill: _____
☐ Maintenance Dose: Inject 400mg SQ every 4 weeks QTY: _____ Refill: _____
☐ Other_____ QTY: _____ Refill: _____

SIMPONI® ☐ SmartJect™ PEN 50mg/0.5mL ☐ PFS 50mg/0.5mL
☐ Inject 50mg subcutaneously once per month QTY: 1 month supply Refills: _____

SIMPONI ARIA™ ☐ 50mg/4ml (12.5mg/ml) in a single use vial
☐ Inject 2mg/kg intravenous infusion over 30 minutes at weeks 0 and 4, then every 8 weeks
Patient Weight (kg): _____ QTY: _____ # of vials Refills: _____
☐ If applicable, enroll patient in *SimponiOne®*

REMICADE® 100mg Vial **Dose:** ☐ 5mg/kg ☐ _____mg/kg *Patient Weight (kg):* _____
☐ IV on weeks 0, 2 and 6 (Induction) QTY: _____ # of vials Refills: 0
☐ IV every 8 weeks (Maintenance Dose) QTY: _____ # of vials Refills: ____
☐ IV every _____ weeks QTY: _____ # of vials Refills: ____
☐ If applicable, enroll patient in *Janssen CarePath*

TYMLOS™ ☐ 1.56 mL Prefilled Multi-Dose Pen QTY: 1 pen (30 day supply) Refill:_____
☐ Inject 80mcg subcutaneously once a day ☐ If applicable, enroll patient in *Together with Tymlos*

FORTEO® 600mcg/2.4ml Pen ☐ If applicable, enroll patient in *FORTEO Connect*
☐ Inject 20mcg SQ Daily as directed QTY: 4 week supply Refill: _____
☐ BD - 31G x 5mm PEN NEEDLES *use as directed w/Forteo pen* QTY: 100 (1 box) Refill: _____

PROLIA® ☐ 60mg PFS ☐ If applicable, enroll patient in *ProliaPlus®*
☐ Inject 60mg subcutaneously every 6 months QTY: 1 Refill: _____

RECLAST® ☐ 5mg/100ml Vial ☐ 5mg IV once yearly QTY: 1 Refill: _____

EVENITY ☐ 105mg/1.17mL PFS (2-count)
☐ Inject 210mg (2-105mg PFS) under the skin once monthly for 12 months
QTY: ☐ 2 PFS (1 month) ☐ 6 PFS (3 months) Refill: _____

OTEZLA® ☐ Prescriber provided Two-Week Starter Pack on _____
Starter: ☐ 28 Day Starter Pack SIG: Take as directed QTY: 55 Refill: 0
☐ 30mg twice daily (recommended) ☐ 30mg daily (for severe renal impairment)
Maintenance: ☐ SIG: Take one tablet by mouth twice daily QTY: 60 Refill: ____
☐ SIG: Take one tablet by mouth daily QTY: 30 Refill: ____
☐ If applicable, enroll in *Otezla SupportPlus™* ☐ If applicable, enroll in *Bridge RX Program*

COSENTYX® ☐ 150 mg Sensoready® Pen ☐ 150 mg PFS ☐ If applicable, enroll patient in *Cosentyx® Connect*
☐ **Starting Dose:** Weeks 0, 1, 2, 3, and 4, then once every 4 weeks
SIG: ☐ Inject 150 mg dose SQ once weekly for 5 weeks. QTY: 5 injection devices Refills: 0
☐ Inject 300 mg dose SQ once weekly for 5 weeks. QTY: 10 injection devices Refills: 0
Each 300 mg dose is given as 2 SQ injections of 150 mg.
☐ **Maintenance Supply:** Once every 4 weeks
SIG: ☐ Inject 150 mg dose SQ once every 4 weeks QTY: _____ Refills: _____
☐ Inject 300 mg dose SQ once every 4 weeks QTY: _____ Refills: _____
Each 300 mg dose is given as 2 SQ injections of 150 mg.

OTHER MEDICATION_____
SIG:_____ **QTY:**_____ **REFILL:**_____

BENLYSTA® ☐ 120mg Vial ☐ 400mg Vial *Patient Weight (kg):* _____
☐ Induction Dose: Infuse 10mg/kg IV every 2 weeks for first 3 doses
☐ Maintenance Dose: Infuse 10mg/kg IV every 4 weeks
QTY: _____# of vials Refill: _____ ☐ If applicable, enroll patient in *BENLYSTA Connects*

☐ **RINVOQ™** 15mg tablet SIG: Take one tablet by mouth once daily QTY: 30 Refill: _____
☐ **OLUMIANT®** 2mg tablet SIG: Take one tablet by mouth once daily QTY: 30 Refill: _____
☐ **XELJANZ®** 5mg tablet SIG: Take one tablet by mouth twice daily QTY: 60 Refill: _____
☐ **XELJANZ XR®** 11mg tablet SIG: Take one tablet by mouth once daily QTY: 30 Refill: _____
If applicable, enroll patient in ☐ *myAbbVie Assist* (Rinvoq) ☐ *Lilly Cares* (Olumiant) ☐ *XELSOURCE℠*

KEVZARA® ☐ 200 mg/1.14 mL | ☐ 150 mg/1.14 mL ☐ Pre-filled Pens ☐ Pre-filled Syringes
Dispense: ☐ Inject 150 mg subcutaneously every other week QTY: 2 Refill: _____
☐ Inject 200 mg subcutaneously every other week QTY: 2 Refill: _____
ANC_____ Platelets_____ Liver Function Tests_____
☐ If applicable, enroll patient in *KevzaraConnect®*

ACTEMRA ☐ ACTPen 162mg/0.9mL ☐ PFS 162mg/0.9mL ☐ Vial 400mg/20mL
Dosing: ☐ < 100kg: Inject 162mg once every other week QTY: _____ Refills: _____
☐ ≥ 100kg: Inject 162mg once every week QTY: _____ Refills: _____
☐ IV: Infuse 4mg/kg IV once every four weeks QTY: _____ Refills: _____
☐ Other: _____ QTY: _____ Refills: _____
☐ If applicable, enroll in *Actemra Access Solutions*

☐ **METHOTREXATE TABS** ☐ **RASUVO** ☐ **OTREXUP**
☐ SQ: Inject ____mg SQ once weekly QTY: _____ Refill: _____
☐ Oral: Take ____mg by mouth once weekly QTY: _____ Refill: _____
☐ Other: _____ QTY: _____ Refill: _____
☐ If applicable, enroll patient in *CORE Connections*

KINERET® 100mg/0.67 mL PFS ☐ If applicable, enroll patient in *KINERET On TRACK*
☐ Inject 100mg (0.67ml) SQ QD QTY: 4 week supply Refill: _____

ORENCIA® *Carton of 4 autoinjectors*: ☐ 125mg PFS ☐ 250mg Vial ☐ 125mg ClickJect™
☐ Inject 125mg SQ weekly
☐ < 60kg Infuse 500mg at weeks 0, 2 and 4, then every 4 weeks thereafter
☐ 60 - 100kg Infuse 750mg at weeks 0, 2 and 4, then every 4 weeks thereafter
☐ > 100kg Infuse 1000mg at weeks 0, 2 and 4, then every 4 weeks thereafter
☐ Other: _____
QTY: 4 week supply Refill: _____ ☐ If applicable, enroll patient in *ORENCIA On Call™*

RITUXAN® ☐ 100mg/10ml Vial ☐ 500mg/50ml Vial QTY: _____# of vials Refill: _____
☐ Infuse 1000mg on day 1 and day 15, repeat course every 24 weeks
☐ Other: _____

STELARA™ ☐ 45mg PFS ☐ 90mg PFS *Patient Weight (kg):* _____
☐ For patients weighing <100kg (220lbs):Inject 45mg SQ initially and 4 weeks later, followed by 45mg every 12 weeks.
☐ For patients weighing > 100kg (220lbs): Inject 90mg SQ initially and 4 weeks later, followed by 90 mg every 12 weeks
☐ Other: _____ QTY: _____ Refill: _____
☐ If applicable, enroll patient in *Janssen CarePath*

TALTZ® 80mg ☐ Autoinjector ☐ Prefilled Syringe
☐ Starting Dose: Inject 160mg SQ at week 0 followed by 80mg at week 4
☐ Maintenance Dose: Inject 80mg SQ every 4 weeks QTY: _____ Refills: _____
☐ Sharps Container ☐ If applicable, enroll patient in *Taltz Together™*

Prescriber's Name / Practice _____ Office Contact_____
Address_____ Suite#_____ City_____ State____ Zip_____
Tel_____ Fax_____ Email_____
License#_____ NPI#_____ UPIN#_____ DEA#_____

Prescriber's Signature (signature required. NO STAMPS)_____ **Date**_____

By signing this form and utilizing our services, you are authorizing QuickRx and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Please fax completed referral form to **QuickRx** at **347-691-3496**
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