

1. DOCTOR/PRESCRIBER FILL OUT AND
 FAX TO: 1-888-773-7386 or Call: 1-888-773-7376

- Faxes will only be accepted from a doctor's office.
- Class II medications cannot be faxed.

Patient Information New Rx Refill

Name: _____
 Address: _____
 City: _____ ST: _____ Zip: _____
 Date of Birth (mm/dd/yyyy): ____/____/____

Phone #1: _____ Phone #2: _____
 Allergies: _____ No Known Allergies
 Health Conditions: _____
 Expected Start Date: ____/____/____

Statement of Medical Necessity

Patient Weight: _____ lbs kg Primary Diagnosis: _____ ICD9 Code: _____
 Indicate treatment failure or intolerance to the following drugs: Methotrexate 6-thioguanine Azathioprine Acitretin Sulfasalazine
 Hydroxyurea Propylthiouracil Cyclosporine Tacrolimus Mycophenolate mofetil Oral methoxsalen plus UVA light (PUVA)
 TB test completed: ____/____/____ Other treatments: _____

Drug Delivery Information If this drug requires Prior Authorization, please send appropriate documentation (notes, test results, etc.)

In Office Delivery Home Delivery for Self Injection/Administration Home Delivery for Home Health Administration
 Other: _____ Contact: _____
 Phone #: _____ Address: _____

Insurance Information Complete here or fax a copy of the patient's insurance card (both sides). Medicare card is required.

Primary: _____ Secondary: _____
 Insured: _____ Insured: _____
 ID #: _____ Group #: _____ ID #: _____ Group #: _____
 Phone #: _____ Rx Drug Card #: _____ Phone #: _____ Rx Drug Card #: _____
 Rx Bin #: _____ Rx PCN #: _____ Rx Grp #: _____ Rx Bin #: _____ Rx PCN #: _____ Rx Grp #: _____

Doctor/Prescriber Information NPI # is mandatory. DEA # is required if the prescription is for controlled substances or Medicare/Medicaid.

Name: _____ Office Contact: _____
 Address: _____ NPI #: _____ DEA #: _____
 City: _____ ST: _____ Zip: _____ Phone #: _____ Fax #: _____

2. COMPLETE THE FOLLOWING Rx FORM -OR- TAPE Rx HERE

| Rx | | | | Date: ____/____/____ |
|--|-----|---|---------|----------------------|
| Drug Name/Form/Strength | Qty | Directions for Use | Refills | |
| <input type="checkbox"/> AMEVIVE® 15mg Vial | | | | |
| <input type="checkbox"/> ENBREL® 25mg Prefilled Syringe <input type="checkbox"/> ENBREL® 25mg multiple-use vial | | | | |
| <input type="checkbox"/> ENBREL® 50mg Prefilled Syringe <input type="checkbox"/> ENBREL® 50mg SureClick™ autoinjector | | | | |
| <input type="checkbox"/> HUMIRA® 20mg/0.4mL Pediatric Prefilled Syringe Kit | | | | |
| <input type="checkbox"/> HUMIRA® 40mg/0.8mL Pen Kit <input type="checkbox"/> HUMIRA® 40mg/0.8mL Prefilled Syringe Kit | | | | |
| <input type="checkbox"/> HUMIRA® 40mg/0.8mL Psoriasis Starter Package Pen Kit | | | | |
| <input type="checkbox"/> REMICADE® 100mg Vial (weight based dosing) | | | | |
| <input type="checkbox"/> SIMPONI™ 50 mg/0.5 mL SmartJect autoinjector <input type="checkbox"/> SIMPONI™ 50 mg/0.5 mL Prefilled Syringe | | | | |
| <input type="checkbox"/> STELARA™ 45mg Prefilled Syringe <input type="checkbox"/> STELARA™ 90mg Prefilled Syringe | | | | |
| Other: _____ | | | | |
| Needles Gauge: _____ Inches: ____ Quantity: ____ Refills: ____ Syringes Volume: _____ Inches: ____ Quantity: ____ Refills: ____ | | | | |
| X _____ Doctor/Prescriber Signature – Dispense as Written Stamped signatures cannot be accepted | | X _____ Doctor/Prescriber Signature – Substitution Permissible Stamped signatures cannot be accepted | | |