

Patient Information	Prescriber + Shipping Information
Patient name: _____ DOB: _____ Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male SSN: _____ Language: _____ Wt: _____ <input type="checkbox"/> kg <input type="checkbox"/> lbs Ht: _____ <input type="checkbox"/> cm <input type="checkbox"/> in Address: _____ Apt/Suite: _____ City: _____ State: _____ Zip: _____ Phone: _____ Alternate: _____ Caregiver name: _____ Relation: _____ Local pharmacy: _____ Phone: _____ Insurance plan: _____ Plan ID: _____ Please fax a copy of front and back of the insurance card(s).	Prescriber name: _____ NPI: _____ Address: _____ Apt/Suite: _____ City: _____ State: _____ Zip: _____ Contact: _____ Phone: _____ Alternate: _____ Fax: _____ Email: _____ If shipping to prescriber: <input type="checkbox"/> First Fill <input type="checkbox"/> Always <input type="checkbox"/> Never

Clinical Information (Please fax all pertinent clinical and lab information)				
Diagnosis: <input type="checkbox"/> M06.9 (Rheumatoid Arthritis) <input type="checkbox"/> M08.0 (Juvenile Idiopathic Arthritis) <input type="checkbox"/> L40.59 (Psoriatic Arthritis) <input type="checkbox"/> M45.9 (Ankylosing Spondylitis) <input type="checkbox"/> _____				
Diagnosis Date: _____ TB test: Yes No Negative Test Date: _____				
Prior Therapy	Yes	No	Reason for Discontinuation of Therapy	Approximate Start Date
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
Comorbidities: _____ Concomitant Medications: _____ Allergies: NKDA Other: _____				

Prescription	Quantity	Refill
<input type="checkbox"/> Cimzia® (certolizumab)	<input type="checkbox"/> Inject 400 mg SQ at weeks 0,2 and 4	6 x 200 mg/mL <input type="checkbox"/> PFS <input type="checkbox"/> Vials
	<input type="checkbox"/> Inject 200 mg SQ every 2 weeks	2 x 200 mg/mL <input type="checkbox"/> PFS <input type="checkbox"/> Vials
	<input type="checkbox"/> Inject 400 mg SQ every 4 weeks	_____ _____ _____
<input type="checkbox"/> Cosentyx® (secukinumab)	<input type="checkbox"/> Inject 150 mg SQ once weekly at weeks 0, 1, 2 and 3	4 x 150 mg/mL <input type="checkbox"/> Sensoready® Pen <input type="checkbox"/> PFS
	<input type="checkbox"/> Inject 300 mg SQ once weekly at weeks 0, 1, 2 and 3	8 X 150 mg/mL _____ _____
	<input type="checkbox"/> Inject 150 mg SQ once weekly at week 4 and every 4 weeks thereafter	1 x 150 mg/mL <input type="checkbox"/> Sensoready® Pen <input type="checkbox"/> PFS
	<input type="checkbox"/> Inject 300 mg SQ once weekly at week 4 and every 4 weeks thereafter	2 x 150 mg/mL _____ _____
<input type="checkbox"/> Enbrel® (etanercept)	<input type="checkbox"/> Inject 50 mg SQ every week	4 x 50 mg/mL <input type="checkbox"/> SureClick® Autoinjector <input type="checkbox"/> PFS <input type="checkbox"/> Vials
	<input type="checkbox"/> Inject _____ mg (0.8 mg/kg x _____ kg) SQ every week	_____ x 25 mg/mL _____ _____

§ Actemra® is located on separate form§

§ Humira®, Kevzara®, Orencia®, Otezla® are available on the Rheumatology Enrollment Form F-R §

§ Simponi®, Simponi Aria®, Stelara®, Taltz®, Xeljanz®, Xeljanz®XR are available on the Rheumatology Enrollment Form S-Z §

Injection Training Provided by: Prescriber's Office Other: _____
 CoxHealth at Home, skilled nursing visits to teach self administration of SQ injection and PRN if needed

Prescriber's Signature: _____ Date: _____

I authorize CoxHealth at Home and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time by providing written notice to CoxHealth at Home

Confidentiality Statement: This message is intended only for the individual or entity to which it is addressed. It may contain information which may be proprietary and confidential. It may also contain privileged, confidential information which is exempt from disclosure under applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA). If you are not the intended recipient, please note that you are strictly prohibited from disseminating or distributing this information (other than to the intended recipient) or copying this information. If you received this communication in error, please notify the sender immediately by calling 1-855-419-4663 to obtain instructions as to the proper destruction of the transmitted material. Thank you.