## Rheumatology (F-Q)

Patient Information	on		Prescriber -	Prescriber + Shipping Information				
Patient name: DOB:			Prescriber name:					
Sex: 🗆 Female 🗅 Male SSN:								
Language: Wt: 🛛 kg 🖾 lbs Ht: 🗅 cm 🗔 in								
Address:			Apt/Suite:	City:	State:	Zip:		
Apt/Suite: City: State: Zip:			Contact:					
Phone: Alternate:			Phone: Alternate:					
Caregiver name: Relation:			Fax:					
Local phar macy: Phone: Phone:			Email:					
Insurance p lan: Plan ID:			If shipping to prescriber: 🗅 First Fill 🕒 Always 🕒 Never					
Please fax a copy o	of front and bac	k of the insurance card(s).						
Clinical Information (Please fax all pertinent clinical and lab information)								
Diagnosis: D M06.9 (Rheumatoid Arthritis) D M08.0 (Juvenille Idiopathic Arthritis) L40.59 (Psoriatic Arthritis)								
L40.54 (Psoriatic Juvenille Arthritis) M45.9 (Ankylosing Spondylitis)								
Diagnosis Date:		TB test: Yes No	Negative Test [	Date:				
			ару	Approximate Sta		rt Date Approximate End Date		
			.,					
Comorbidities:								
Concomitant Medi cations:								
Allergies: NKDA	Other:		0.107	stitu <i>r</i>			Refill	
Prescription			Quar	itity			Kellii	
□Humira <sup>®</sup>								
citrate free	Inject 40mg 9	SQ every other week	2 x	40mg/0.4mL	Pens			
(adalimumab)								
						- PFS		
🔲 Kevzara <sup>®</sup>		ng SQ every other week		2 x 150 mg/1.14mL				
(sarilumab)	□Inject 200 r	ng SQ every other week	2	2 x 200 mg/1.14mL				
Olumiant <sup>®</sup>	Take 2mg by mouth once daily		3(	30 x 2mg		Tablets		
(baricitinib)								
	□ Infuse	mg IV at week 0, 2, 4 and every 4	weeks	x 250 mg		Vials		
	thereafter							
□Orencia <sup>®</sup> (abatacept)	RA or PsA dosing: <60kg: 500mg, 60-100kg: 750mg, >100kg: 1,0		,000mg	00mg				
	□ Infuse mg IV on week 0 <b>only</b>			v 250 mg				
				x 250 mg		Vials 0		
	RA or PsA dosing:	<60kg: 500mg, 60-100kg: 750mg, >100kg: 1	,000mg	Omg				
	Inject 125 mg SQ once weekly		4	4 x 125 mg/mL		PFS		
			47			:t™		
	Take as directed per package instructions		55	tablets	28-day sta	rter pack	0	
□ Otezla <sup>®</sup>	•	twice daily by mouth		30 mg tablets		•	· · · · · · · · · · · · · · · · · · ·	
(apremilast)		twice daily by mouth	00.	x so my tablets				
+								
Please the following forms for additional medications: Actemra, Rheumatology A-R, Rheumatology S-Z								
Injection Training Provided by: Drescriber's Office D CoxHealth at Home, skilled nursing visits to teach self administrationof SQ injection and PRN D training								
Prescriber's Signature:								
P rescriber's Signature:					_ Date:			
	Lauthorize Couldoalth at Users	and its concentrations to act as an agent to initiate and account	the incurrence prior suff	tion process for this processintic	l anu futuro fillo			

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.

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