APEX SPECIALTY PHARMACY

RHEUMATOLOGY

Benefit Investigation + Prior Authorization Support

Date ______________________

Ship to: ☐ Patient ☐ Provider

PATIENT INFORMATION::

Patient Name:		Prescriber:	
Street Address:		NPI:	
City, State, Zip:		Group:	
Phone #1:		Street Address:	
Phone #2:		City, State, Zip:	
Social Security:		Office Phone:	
Date of Birth:	/ /	Office FAX:	
Sex:	☐ M ☐ F	Primary Contact:	

PLEASE SEND INSURANCE CARD AND DEMOGRAPHIC INFORMATION

DIAGNOSIS (ICD-10)

☐ M45.____ Ankylosing Spondylitis ☐ M08.____ JIA ☐ M32.9 SLE

☐ L40.____ Psoriatic Arthritis ☐ M06.____ Rheumatoid Arthritis ☐ H20.____ Uveitis

CURRENT / PREVIOUS THERAPIES FOR THIS CONDITION

DMARDs	☐ Azathioprine ☐ Leflunomide ☐ Methotrexate ☐ Plaquenil ☐ Sulfasalazine ☐ Rasuvo/Otrexup
Biologics	☐ Actemra ☐ Benlysta ☐ Cimzia ☐ Cosentyx ☐ Enbrel ☐ Humira ☐ Olumiant ☐ Orencia ☐ Otezla ☐ Remicade ☐ Rituxan ☐ Simponi ☐ Stelara ☐ Taltz ☐ Xeljanz

PPD/Chest X-Ray for TB? ☐ Yes ☐ No Drug Allergies:

PRESCRIPTION INFORMATION

☐ Actemra SC	☐ 162mg/0.9ml PFS	☐ 162mg SQ every other week (qty 2) ☐ 162mg SQ once weekly (qty 4)	Refill:
☐ Benlysta SC	☐ 200mg autoinjector ☐ 200mg PFS	☐ Inject 200mg once weekly	Refill:
☐ Cimzia	☐ 200x2 PFS ☐ 200x2 LYO	☐ Start: Inject 400mg SQ at weeks 0, 2, and 4 (qty 3 kits) ☐ Maint: Inject _____mg SQ every: ☐ 2 ☐ 4 wks (qty _____)	Refill: 0 Refill:
☐ Cosentyx	☐ 150mg Sensoready PEN ☐ 150mg PFS	☐ Start: Inject _____mg SQ at weeks 0, 1, 2, 3 and 4 (qty _____) ☐ Maint: Inject _____mg SQ every 4 weeks (qty _____)	Refill: 0 Refill:
☐ Enbrel	☐ 50mg Enbrel Mini ☐ 50mg Sureclick ☐ 25mg ☐ 50mg PFS	☐ Inject 50mg SQ TWICE a week, 72-96 hrs apart (qty 8) ☐ Inject 50mg SQ ONCE a week (qty 4) ☐ Inject 25mg SQ TWICE a week, 72-96 hrs apart (qty 8)	Refill:
☐ Humira **citrate free*	☐ 40mg/0.8ml PEN ☐ 40mg/0.8ml PFS ☐ 40mg/0.4ml PEN* ☐ 40mg/0.4ml PFS*	☐ Inject 40mg SQ every-other-week (qty 2) ☐ Inject 40mg SQ ONCE a week (qty 4) ☐ Inject 80mg SQ Day 1, 40mg Day 8, then 40mg every-other-week (qty 4/2)	Refill:
☐ Kevzara	150mg ☐ PFS ☐ PEN 200mg ☐ PFS ☐ PEN	☐ Inject _____mg SQ every 2 weeks (qty 2)	Refill:
☐ Olumiant	☐ 2mg Tablet	☐ Take 1 tablet by mouth once daily (qty 30)	Refill:
☐ Orencia	☐ 125mg ClickJect ☐ 125mg PFS	☐ Inject 125mg SQ ONCE a week (qty 4)	Refill:
☐ Otezla	☐ Starter Kit ☐ 30mg Tablet	☐ Take Starter Dosing per instructions (qty 55 // 28 days) [☐ *Office provided*] ☐ Take 1 tablet by mouth twice daily (qty 60 // 30 days)	Refill: 0 Refill:
☐ Simponi	☐ 50mg SmartJect ☐ 50mg PFS	☐ Inject 50mg SQ every 4 weeks (qty 1)	Refill:
☐ Stelara	☐ 45mg PFS ☐ 90mg PFS	☐ Start: Inject ____mg SQ day 0, then on day 28 (qty 2) ☐ Maint: Inject ____mg SQ every 12 weeks (qty 1) **Pt. weight ______lbs*	Refill: 0 Refill:
☐ Taltz	☐ 80mg Autoinjector ☐ 80mg PFS	☐ Start: Inject 2-80mg (160mg) SQ at Week 0, then every 4 weeks (qty 2) ☐ Maint: Inject 80mg SQ every 4 weeks (qty 1)	Refill: 0 Refill:
☐ Xeljanz	☐ 5mg Tablet	☐ Take 5mg orally twice daily as directed (qty 60)	Refill:
☐ Xeljanz XR	☐ 11mg Tablet	☐ Take 11mg orally once daily as directed (qty 30)	Refill:

PRESCRIBER SIGNATURE ____________________________ ____________________________ DATE ____ / ____ / ____

PRODUCT SUBSTITUTION PERMITTED DISPENSE AS WRITTEN

Phone: 855.257.2584 || Fax: 866.680.3539