For assistance, contact your pharmacy representative: ______________________ Phone: ______________________ **(For providers only)**

**PLEASE CONSIDER SENDING YOUR PRESCRIPTION ELECTRONICALLY. ALL OF OUR PHARMACY LOCATIONS ACCEPT ELECTRONIC PRESCRIPTIONS.**

**Note:** This form is intended for prescriber use only, if faxed, the fax must come from MD office or hospital **(may not be faxed by patient)**.

allianceRx Walgreens + PRIME

**Rheumatoid Arthritis**
Prescription/Pharmacy Intake Form

Pharmacy: ______________________
Pharmacy Fax: ______________________ Pharmacy Phone: ______________________
**Date Needed:** ______________ **Ship To:** ☐Prescriber's Office ☐Patient's Home ☐Other: ______________________

## PATIENT INFORMATION

Patient name: ______________________ DOB: ______________ ☐Male ☐Female
Address: ______________________ City: ______________ State: ______ Zip code: ______________
Phone # (Daytime): ______________________ Phone # (Evening): ______________________
E-mail Address: ______________________ Case Manager: ______________________
Insurance provider **(Please include copy of front and back of card)**: ______________________
ID #: ______________ Policy/Group #: ______________ Phone #: ______________ ☐Patient is eligible for Medicare
Name of Insured: ______________________ Employer: ______________________
Relationship to Patient: ☐Self ☐Other: ______________ Prescription Card: ☐Yes ☐No Carrier: ______________ Policy/Group #: ______________
Will there be access to anaphylactic medications and oxygen at the administration site? ______________________

## CLINICAL ASSESSMENT – Please complete ALL sections to avoid delays in filling prescription

☐Patient is new to therapy ☐Patient is currently on therapy Start date: ______________ ☐Physician Provides Injection Training Injection/Infusion Date: ______________
Primary Diagnosis Code and Condition (ICD-10): ______________________ Other Diagnosis/Conditions: ______________________
Joints Affected: ______ Number of Tender Joints: ______ Number of Swollen Joints: ______ Current Weight: ______________ Date: ______________
☐New Therapy Induction ☐Therapy Change ☐Therapy Continuation | Weeks Completed ☐0 ☐2 ☐4 ☐6 | Stop Date: ______________
ESR: ______________ Date: ______________ CRP: ______________ Date: ______________ TB Results: ______________ Date: ______________
Allergies: ______________________

## MEDICATION

**Actemra (tocilizumab)**
☐162mg Syringe
☐80mg/4mL Vial
☐200mg/10mL Vial
☐400mg/20mL Vial
Directions: ______________ Quantity: ______ Refills: ______

**Cimzia (certolizumab pegol)**
☐(6) 200mg Starter Kit
Directions: ______________ Quantity: ______ Refills: ______
☐(2) 200mg ☐Syringe ☐Vial
Directions: ______________ Quantity: ______ Refills: ______

**Enbrel (etanercept)**
☐25mg ☐Syringe ☐Vial
☐50mg ☐Syringe ☐SureClick™ Pen ☐Mini™ Cartridge
Directions: ______________ Quantity: ______ Refills: ______

**Humira (adalimumab)**
☐10mg/0.2ml Prefilled Syringe Pediatric
☐20mg/0.4ml Prefilled Syringe Pediatric
☐40mg/0.8ml ☐Pen ☐Prefilled Syringe
Directions: ______________ Quantity: ______ Refills: ______

**Humira citrate free (adalimumab)**
☐10mg/0.1ml citrate free Prefilled Syringe Pediatric
☐20mg/0.2ml citrate free Prefilled Syringe Pediatric
☐40mg/0.4ml citrate free ☐Pen ☐Prefilled Syringe
Directions: ______________ Quantity: ______ Refills: ______

**Kevzara (sarilumab)**
☐150mg ☐Syringe ☐Pre-filled Pen
☐200mg ☐Syringe ☐Pre-filled Pen
Directions: ______________ Quantity: ______ Refills: ______

**Olumiant**
☐2mg Tablets
Directions: ______________ Quantity: ______ Refills: ______

**Orencia (abatacept)**
☐50mg Prefilled Syringe
☐87.5mg Prefilled Syringe
☐125mg ☐Clickject Pen ☐Prefilled Syringe
☐250mg Vial
Directions: ______________ Quantity: ______ Refills: ______

**Inflectra (infliximab-dyyb)**
☐100mg Vial
Directions: ______________ Quantity: ______ Refills: ______

**Remicade (infliximab)**
☐100mg Vial
Directions: ______________ Quantity: ______ Refills: ______

**Renflexis (infliximab-abda)**
☐100mg Vial
Directions: ______________ Quantity: ______ Refills: ______

**Rinvoq (upadacitinib)**
☐15mg Tablet
Directions: ______________ Quantity: ______ Refills: ______

**Rituxan (rituximab)**
☐100mg Vial
☐500mg Vial
Directions: ______________ Quantity: ______ Refills: ______

**Simponi (golimumab)**
☐50mg ☐Syringe ☐Smartject
Directions: ______________ Quantity: ______ Refills: ______

**Simponi Aria (golimumab)**
☐50mg Vial
Directions: ______________ Quantity: ______ Refills: ______

**Xeljanz (tofacitinib)**
☐5mg Tablet
Directions: ______________ Quantity: ______ Refills: ______

**Xeljanz XR (tofacitinib)**
☐11mg Tablet
Directions: ______________ Quantity: ______ Refills: ______

**Other**
☐ ______________________
Directions: ______________ Quantity: ______ Refills: ______

**Methotrexate** – Can only be ordered with other specialty meds.
☐2.5mg Tablet
Directions: ______________ Quantity: ______ Refills: ______

**I authorize, by my signature below, the dispensing of appropriate needles and syringes, in a sufficient quantity, required for the administration of injectable products by patient or caregiver. Authorization for supplies runs concurrently with the number of refills or time frame specified for the drug.**

## PRESCRIBER INFORMATION

Prescriber's name: ______________________ Practice/facility: ______________________
Address: ______________________ City: ______________ State: ______ Zip code: ______________
Office contact: ______________________ Phone: ______________ Fax: ______________
Email: ______________________ Best time to call: ______________ Preferred method of contact: ☐Email ☐Phone ☐Fax
State license #: ______________ DEA #: ______________ NPI #: ______________ Medicaid UPIN #: ______________

In order for a brand name product to be dispensed, the prescriber must handwrite **"Brand Necessary"** or **"Brand Medically Necessary"** or your state specific required language after their signature.
I certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge. Prescriber's signature required on one of the lines below.

______________________ ______________________ ______________
Dispense as written Substitution permitted Date

**The prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.**

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Drug names are the property of their respective owners.
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