benevere PHARMACY

60 Market Center Dr. #103, Collierville, TN 38017
O: 901.316.5752 TP: 855.344.8724 F: 901.316.5760
TF: 844.588.5560
beneverepharmacy.com

TODAY'S DATE: _____

☐ NEW PATIENT ☐ CURRENT PATIENT

Inflammatory Arthritis Oral Medication Referral Form

PATIENT INFORMATION

Patient Name _____

Address _____

City _____ State _____ ZIP _____

Home Phone _____ Cell _____

DOB _____ SSN _____

Drug Allergies _____ ☐ Male ☐ Female

PRESCRIBER INFORMATION

Prescriber Name _____ DEA _____

NPI# _____ Tax ID _____

Practice Name _____

Address _____ Suite _____

City _____ State _____ ZIP _____

Office Phone _____ Fax _____

COMPLETE OR FAX FRONT AND BACK COPIES OF INSURANCE, PRESCRIPTION AND/OR CO-PAY ASSISTANCE CARDS

Primary Prescription Insurance _____

Insurance Phone _____

Secondary Prescription Insurance (if applicable) _____

Insurance Phone _____

CLINICAL INFORMATION

Primary diagnosis _____ ICD-10 code _____ Patient weight _____ lbs or kgs (please circle) TB/PPD Test Given? ☐ Yes ☐ No

Prior Treatments:

☐ 5-ASA ☐ Azathioprine ☐ Azulfidine ☐ Celebrex ☐ Corticosteroids ☐ Gold Salts ☐ Immunosuppressants ☐ MTX ☐ NSAIDS ☐ Penicillamine ☐ Plaquenil

☐ Previous biologic _____ ☐ Other _____

Currently on a biologic? ☐ Yes ☐ No How long? _____ Date of last dose ____/____/____

This Rx is: ☐ New therapy ☐ Continuing previous treatment on this agent

DRUG NAME		DIRECTIONS FOR USE (PLEASE CHECK ONE OR MORE)	QUANTITY	REFILLS
☐ Olumiant®	☐ 2mg Tablet	☐ One tablet once daily	30 Day Supply	
☐ Otezla®		☐ **Starter Pack**: Take per package directions.	28 Day Supply	0
		Maintenance: Take 30mg by mouth twice a day.	30 Day Supply	
		Bridge: Take 30mg by mouth twice a day, dispensed by OSP. Titration date _____	14 Day Supply	12
☐ Rinvoq®	☐ 15 mg Tablet	☐ One tablet once daily	30 Day Supply	
☐ Xeljanz®		☐ Take 5mg tablet twice daily	30 Day Supply	
☐ Xeljanz XR ®		☐ Take 11mg tablet once daily		

Deliver to:
☐ Patient's Home
☐ Physician's Office
☐ 1st dose to MD's Office, remaining refills to patient's home

Training:
☐ Patient has received injection training
☐ Physician's office to provide injection training
☐ Pharmacy to coordinate injection training

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing below, I hereby authorize CVS Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.

Prescriber's Signature (signature required. NO STAMPS) _____ Date _____