benevere PHARMACY

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beneverepharmacy.com

TODAY'S DATE: _____

☐ NEW PATIENT ☐ CURRENT PATIENT

Inflammatory Arthritis Injectable 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
☐ Actemra®	☐162mg Prefilled Syringe ☐162mg Pen	☐ < 100kg, Inject 162mg subcutaneously every other week ☐ ≥ 100kg, Inject 162 mg subcutaneously every week		
☐ Benlysta	☐200mg Prefilled Syringe ☐200mg Pen	☐ Inject 200mg subcutaneously every week	28 Day Supply	
☐ Cimzia® 200mg Prefilled Syringe		☐ **Induction**: Inject 400 mg subcutaneously on day 1, week 2, and week 4		
		☐ **Maintenance**: Inject 200mg subcutaneously every other week ☐ **Maintenance**: Inject 400mg subcutaneously every 4 weeks		
☐ Cosentyx®	☐ 150mg Sensoready Pen ☐ 150mg Prefilled Syringe	☐ **Induction**: Inject _____mg subcutaneously at weeks 0,1,2, and 3	28 Day Supply	0
		☐ **Maintenance**: Inject _____mg subcutaneously every 4 weeks	28 Day Supply	
☐ Enbrel® ☐ 25mg ☐ 50mg	☐ Sureclick Autoinjector ☐ Prefilled syringe ☐ Mini	☐ Inject subcutaneously weekly ☐ Other _____		
☐ Humira® Citrate Free	☐ Pens (40mg) ☐ Prefilled syringe	☐ Inject 20mg subcutaneously every other week ☐ Inject 40mg subcutaneously every other week		
☐ Kevzara® ☐ 150mg ☐ 200mg	☐ Prefilled Syringe ☐ Pen	☐ Inject 1 syringe subcutaneously every other week		
☐ Orencia®	☐ 250mg Vial ☐ 125mg Prefilled syringe ☐ 125mg ClickJect	☐ **Infusion**: Initial dose _____ mg intravenously (no refill) ☐ **Subcutaneous**: Inject 125mg subcutaneous weekly (first dose, one day after infusion)		
☐ Otrexup®	☐ 10mg ☐ 12.5mg ☐ 15mg ☐ 17.5mg ☐ 20mg ☐ 22.5mg ☐ 25mg	Inject 1 pen subcutaneously every week		
☐ Rasuvo®	☐ 7.5mg ☐ 10mg ☐ 12.5mg ☐ 15mg ☐ 17.5mg ☐ 20mg ☐ 22.5mg ☐ 25mg ☐ 27.5mg ☐ 30mg	Inject 1 pen subcutaneously every week		
☐ Simponi® 50mg/0.50ml	☐ SmartJect™ ☐ Prefilled syringe	☐ Inject 50mg subcutaneously every 4 weeks		
☐ Stelara®		☐ ≤100kg, Inject 45 mg subcutaneously day 1, week 4, and then every 12 weeks ☐ >100kg, Inject 90 mg subcutaneously day 1, week 4, and then every 12 weeks	28 Day Supply	0
			84 Day Supply	
☐ Taltz®	☐ 80mg Prefilled syringe ☐ 80mg Pen	☐ **Starting Dose**: Inject under the skin two 80 mg injections on Day 1. ☐ **Starting Dose w/ Induction**: Inject under the skin two 80 mg injections on Day 1, then begin first induction dose 2 weeks later. ☐ **Induction Dose**: Inject under the skin one 80 mg injection every 2 weeks (weeks 4-10) ☐ **Final Induction Dose**: Inject under the skin one 80 mg injection (week 12). ☐ **Maintenance Dose**: Inject under the skin one 80 mg injection every 4 weeks.	2	0
			3	0
			2	1
			1	0
			1	

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 _____