

Rheumatology (drugs F-R)

(Humira®, Kevzara®, Orencia®, Otezla®)



toll-free phone 855.611.3399
toll-free fax 855.423.8300

Patient Information	Prescriber + Shipping Information
Patient name: _____ DOB: _____	Prescriber name: _____
Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male SSN: _____	NPI: _____
Language: _____ Wt: _____ <input type="checkbox"/> kg <input type="checkbox"/> lbs Ht: _____ <input type="checkbox"/> cm <input type="checkbox"/> in	Address: _____
Address: _____	Apt/Suite: _____ City: _____ State: _____ Zip: _____
Apt/Suite: _____ City: _____ State: _____ Zip: _____	Contact: _____
Phone: _____ Alternate: _____	Phone: _____ Alternate: _____
Caregiver name: _____ Relation: _____	Fax: _____
Local pharmacy: _____ Phone: _____	Email: _____
Insurance plan: _____ Plan ID: _____	If shipping to prescriber: <input type="checkbox"/> First Fill <input type="checkbox"/> Always <input type="checkbox"/> Never

Please fax a copy of front and back of the insurance card(s).

Clinical Information (Please fax all pertinent clinical and lab information)			
Diagnosis: <input type="checkbox"/> M06.9 (Rheumatoid Arthritis) <input type="checkbox"/> M08.0 (Juvenile Idiopathic Arthritis) <input type="checkbox"/> L40.59 (Psoriatic Arthritis) <input type="checkbox"/> L40.54 (Psoriatic Juvenile Arthritis) <input type="checkbox"/> M45.9 (Ankylosing Spondylitis) <input type="checkbox"/> _____			
Diagnosis Date: _____ TB test: <input type="checkbox"/> Yes <input type="checkbox"/> No Negative Test Date: _____			
Prior Therapy <input type="checkbox"/> Yes <input type="checkbox"/> No	Reason for Discontinuation of Therapy	Approximate Start Date	Approximate End Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
Comorbidities: _____			
Concomitant Medications: _____			
Allergies: <input type="checkbox"/> NKDA <input type="checkbox"/> Other: _____			

Prescription	Quantity	Refill	
§ Actemra®, Cimzia®, Cosentyx®, Enbrel® are available on the Rheumatology Enrollment Form A-E §			
<input type="checkbox"/> Humira® (adalimumab) <i>Adults & Pediatrics</i> <i>Age ≥ 2 years</i>	<input type="checkbox"/> Inject 10 mg subcut every other week (10 to <15 kg)	<input type="checkbox"/> 2 x 10 mg/0.2mL	PFS <input type="checkbox"/> Pens <input type="checkbox"/> PFS
	<input type="checkbox"/> Inject 20 mg subcut every other week (15 to <30 kg)	<input type="checkbox"/> 2 x 20 mg/0.4mL	
	<input type="checkbox"/> Inject 40 mg subcut every other week (≥30 kg)	<input type="checkbox"/> 2 x 40 mg/0.8mL	
	<input type="checkbox"/> Inject 40 mg subcut once weekly	<input type="checkbox"/> 4 x 40 mg/0.8mL	
<input type="checkbox"/> Kevzara® (sarilumab)	Inject 150 mg subcut every other week	2 x 150 mg/1.14mL	PFS
	Inject 200 mg subcut every other week	2 x 200 mg/1.14mL	
<input type="checkbox"/> Orencia® (abatacept)	<input type="checkbox"/> Inject 125 mg subcut once weekly	<input type="checkbox"/> 4 x 125 mg/mL	<input type="checkbox"/> PFS <input type="checkbox"/> ClickJect™
<input type="checkbox"/> Otezla® (apremilast)	<input type="checkbox"/> Take as directed per package instructions	<input type="checkbox"/> 55 tablets	28-day starter pack
	<input type="checkbox"/> Take 30 mg by mouth twice daily	<input type="checkbox"/> 60 x 30 mg tablets	
	<input type="checkbox"/> _____	<input type="checkbox"/> _____	
<input type="checkbox"/> Rinvoq® (upadacitinib)	<input type="checkbox"/> Take 1 tablet (15 mg) by mouth once daily	<input type="checkbox"/> 30 x 15 mg tablets	

§ Simponi®, Simponi Aria®, Stelara®, Xeljanz®, Xeljanz® XR are available on the Rheumatology Enrollment Form S-Z §

Injection Training Provided by: ☐ Prescriber's Office ☐ Pharmacy ☐ Other: _____

Per state-specific law, prescriptions will be dispensed as generic, if applicable, unless notated otherwise: _____

Stamp signature not allowed, physician signature required.

Prescriber's Signature: _____ Date: _____

I authorize Thrifty White Specialty Pharmacy 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 Thrifty White Specialty Pharmacy.

Confidentiality Statement: This message is intended only for the individual or entity to which it is addressed. It may contain information which may be proprietary and confidential. It may also contain privileged, confidential information which is exempt from disclosure under applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA). If you are not the intended recipient, please note that you are strictly prohibited from disseminating or distributing this information (other than to the intended recipient) or copying this information. If you received this communication in error, please notify the sender immediately by calling 855-611-3399 or by emailing specialty@thriftywhite.com to obtain instructions as to the proper destruction of the transmitted material. Thank you.

www.thriftywhite.com

toll-free phone: **855-611-3399** | toll-free fax: **855-423-8300**

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