RHEUMATOLOGY [A-K]

Golden HealthCare Specialty
Phone: 877-469-4334 Fax: 888-201-9023 NPI #: 1427479344
242 Palisade Avenue | Garfield, NJ 07026 goldhcrx.com

Today's Date _____ Needs by _____ Ship to Patient at ☐ Home ☐ Office ☐ Other _____

PATIENT INFORMATION

Patient Name _____
Address _____
City _____ State _____ Zip _____
Phone _____ Alt Phone _____
Email _____
SS# _____ DOB _____
☐ Male ☐ Female Height ____ ft ____ in Weight _____ ☐ kg ☐ lb
☐ **SEND COPY OF PATIENT'S INSURANCE CARDS: FRONT AND BACK**

PRESCRIBER INFORMATION

Prescriber Name _____
DEA# _____ NPI# _____ License# _____
Address/Suite _____
City _____ State _____ Zip _____
Phone _____ Fax _____
Email _____
Contact Person _____
Best Contact via: ☐ Phone ☐ Fax ☐ Email ☐ Other _____

DIAGNOSIS/CLINICAL INFORMATION (PLEASE SEND A COPY OF ALL PERTINENT LABS AND CHART NOTES)

ICD-10 Diagnosis: ☐ **M06.9** Rheumatoid Arthritis ☐ **L40.50** Psoriatic Arthritis ☐ **M45.9** Ankylosing Spondylitis ☐ **H20.9** Uveitis ☐ **M32.10** Systemic Lupus Erythematosus ☐ **Other ICD-10** _____ Diagnosis _____

Allergies: _____ **Does patient have a latex allergy?** ☐ No ☐ Yes

Prior Failed Medications: Biologics: ☐ Cimzia ☐ Cosentyx ☐ Enbrel ☐ Humira ☐ Orencia ☐ Remicade ☐ Simponi ☐ Stelara ☐ Taltz ☐ Methotrexate ☐ Soriatane ☐ Cyclosporine ☐ PUVA/UVB ☐ Topicals (list): _____ ☐ Other: _____

TB Test: ☐ No ☐ Yes Date: _____ Results: _____ (Please send lab results)

PRESCRIPTION INFORMATION

MEDICATION & DOSAGES	DIRECTIONS	QTY	REFILLS
☐ **Actemra®** *(tocilizumab)* ☐ 162 mg/0.9 ml Autoinjector ☐ 162 mg/0.9 ml PFS ☐ 80mg/4mL Vial ☐ 200mg/10mL Vial ☐ 400mg/20mL Vial ☐ *Enroll in Actemra Access Solutions*	<u>Rheumatoid Arthritis</u> **Inject** 162mg subcutaneously ☐ every other week **OR** ☐ everyweek (≥ 100kg) ☐ **Infuse** _____ mg (_____ mg/kg) every 4 weeks <u>Polyarticular Juvenile Idiopathic Arthritis</u> *Subcutaneous:* **Inject** 162mg subcutaneously ☐ every 3 weeks (<30kg) **OR** ☐ every 2 weeks (≥30kg) *Intravenous:* ☐ **Infuse** _____ mg (10mg/kg) every 4 weeks (<30kg) ☐ **Infuse** _____ mg (8mg/kg) every 4 weeks (≥30kg) <u>Systemic Juvenile Idiopathic Arthritis</u> *Subcutaneous:* **Inject** 162mg subcutaneously ☐ every 2 weeks (<30kg) **OR** ☐ every week (≥30kg) *Intravenous:* ☐ **Infuse** _____ mg (12mg/kg) every 2 weeks (<30kg) ☐ **Infuse** _____ mg (8mg/kg) every 2 weeks (≥30kg)	4 Week Supply	_____
☐ **Benlysta®** *(belimumab)* ☐ 120mg/5ml Vial ☐ 400mg/20ml Vial ☐ 200mg/ml Autoinjector ☐ 200mg/ml PFS ☐ *Enroll in BENLYSTA Connects*	<u>Subcutaneous Administration in Adults</u> ☐ **Inject** 200mg subcutaneously once a week <u>Infusion Administration in Adults</u> ☐ **Load**: Infuse _____ mg (10 mg/kg) at weeks 0,2, and 4, then every 4 weeks thereafter ☐ **Maintenance**: Infuse _____ mg (10 mg/kg) every 4 weeks	4 Week Supply Loading Dose 4 Week Supply	_____ 0 _____
☐ **Cimzia®** *(certolizumab pegol)* ☐ 200mg x2 PFS ☐ 200mg x2 Vial ☐ *Enroll in CIMplicity*	☐ **Starter Kit (200mg x 6 Vials or 6 PFS)**: Inject 400mg subcutaneously at weeks 0,2, and 4 ☐ **Maintenance**: Inject 400mg subcutaneously every 4 weeks ☐ **Maintenance**: Inject 200mg subcutaneously every 2 weeks	1 Cimzia Starter 4 Week Supply	0 _____
☐ **Cosentyx®** *(secukinumab)* ☐ 300mg (2x150mg) Pen ☐ 150mg Pen ☐ 300mg (2x150mg) PFS ☐ 150mg PFS ☐ *Enroll in Consentyx Connect*	<u>Psoriatic Arthritis or Ankylosing Spondylitis</u> ☐ **Load**: Inject 150mg at weeks 0, 1, 2, 3, 4 and every 4 weeks thereafter ☐ **Maintenance**: Inject 150mg every 4 weeks ☐ **Alternate dose:** Inject 300mg every 4 weeks <u>Psoriatic Arthritis with Med-Severe Plaque Psoriasis</u> ☐ **Load**: Inject 300mg at weeks 0, 1, 2, 3, 4 and every 4 weeks thereafter ☐ **Maintenance**: Inject 300mg every 4 weeks	5 Week Supply 4 Week Supply 5 Week Supply 4 Week Supply	0 _____ 0 _____
☐ **Enbrel®** *(etanercept)* ☐ 50mg SureClick® ☐ 50mg PFS ☐ 50mg Mini® ☐ 25mg PFS ☐ 25mg Vial ☐ *Enroll in Enbrel Support*	**Inject** ☐ 50mg subcutaneously once a week **OR** ☐ 50mg subcutaneously twice a week, for 3 months followed by 50mg once weekly <u>Pediatric Directions</u> ☐ **Inject** 50mg subcutaneously once a week (≥63kg) ☐ **Inject** _____ mg (0.8mg/kg) subcutaneously once a week (<63kg) ☐ **Inject** 25mg subcutaneously once a week	4 Week Supply	_____
☐ **Evenity** *(romosozumab-aqqg)* ☐ 105mg/1.17mL PFS (2-ct) ☐ *Enroll in Amgen Assist*	☐ Inject 210mg (two-105mg injections) subcutaneously once a month for 12 months	2 PFS (1 month) 6 PFS (3 month)	_____ _____
☐ **Forteo** *(teriparatide)* ☐ 600mcg/2.4ml Pen ☐ *Enroll in FORTEO Connect*	☐ Inject 20mcg subcutaneously daily as directed ☐ 31G x 5mm Pen Needles use as directed with Forteo pen	4 week supply 100 (1 box)	_____ _____
Humira® Citrate Free *(adalimumab)* ☐ 40mg/.08 ml Pen ☐ 40mg/.08 ml PFS **Humira®** *(adalimumab)* ☐ 40mg/.08 ml Pen ☐ 40mg/.08 ml PFS <u>Pediatric Dosing</u> ☐ 10mg PFS ☐ 20mg PFS **Humira® Citrate Free** ☐ 40mg/0.4ml Pen ☐ 40mg/0.4ml PFS **Humira®** ☐ 40mg/0.8ml Pen ☐ 40mg/0.8ml PFS ☐ *Enroll in Ambassador Program*	☐ **Load**: Inject 80mg on day 1, then 40mg on day 8, then 40mg every other week ☐ **Maintenance**: Inject 40mg subcutaneously every other week ☐ **Maintenance**: Inject 40mg subcutaneously once a week <u>Pediatric Directions</u> ☐ **Inject** 10mg subcutaneously every other week (10kg to< 15kg) ☐ **Inject** 20mg subcutaneously every other week (15kg to <30kg) ☐ **Inject** 40mg subcutaneously every other week (≥30kg)	Loading Dose Loading Dose 4 Week Supply 4 Week Supply 4 Week Supply	0 _____ _____ _____ _____
☐ **Kevzara®** *(sarilumab)* ☐ 200mg/1.4ml Pen ☐ 150mg Pen/1.4ml ☐ 200mg/1.4ml PFS ☐ 150mg/1.4ml PFS ☐ *Enroll in KevzaraConnect®*	☐ **Inject** 200mg subcutaneously every 2 weeks ☐ **Inject** 150mg subcutaneously every 2 weeks	4 Week Supply	_____
☐ **Kineret** *(anakinra)* ☐ 100mg/0.67 mL PFS ☐ *Enroll in Kineret onTRACK*	☐ **Inject** 100mg (0.67ml) subcutaneously daily	4 Week Supply	_____

Prescriber's Signature (*no stamps*) _____ ☐ **Dispense as Written** **Date** _____

By signing above, I authorize GOLDEN HEALTHCARE SPECIALTY PHARMACY and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

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PATIENT INFORMATION

Patient Name _____
Address _____
City _____ State _____ Zip _____
Phone _____ Alt Phone _____
Email _____
SS# _____ DOB _____
☐ Male ☐ Female Height ____ ft ____ in Weight _____ ☐ kg ☐ lb
☐ **SEND COPY OF PATIENT'S INSURANCE CARDS: FRONT AND BACK**

PRESCRIBER INFORMATION

Prescriber Name _____
DEA# _____ NPI# _____ License# _____
Address/Suite _____
City _____ State _____ Zip _____
Phone _____ Fax _____
Email _____
Contact Person _____
Best Contact via: ☐ Phone ☐ Fax ☐ Email ☐ Other _____

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Allergies: _____ **Does patient have a latex allergy?** ☐ No ☐ Yes

Prior Failed Medications: Biologics: ☐ Cimzia ☐ Cosentyx ☐ Enbrel ☐ Humira ☐ Orencia ☐ Remicade ☐ Simponi ☐ Stelara ☐ Taltz
☐ Methotrexate ☐ Soriatane ☐ Cyclosporine ☐ PUVA/UVB ☐ Topicals (list): _____ ☐ Other: _____

TB Test: ☐ No ☐ Yes Date: _____ Results: _____ (Please send lab results)

PRESCRIPTION INFORMATION

MEDICATION & DOSAGES	DIRECTIONS	QTY	REFILLS
☐ **Olumiant®** *(baricitinib)* ☐ 2mg tab ☐ 1mg tab ☐ *Enroll in Lilly Cares* *(renal dose adjustment)*	☐ **Take** 2mg by mouth daily	30 Tablets	_____
☐ **Orencia®** *(abatacept)* ☐ 125mg ClickJect™ ☐ 125mg PFS ☐ 250mg Vial **Pediatric Dosing** ☐ 50mg PFS ☐ 87.5mg PFS ☐ 125mg PFS ☐ 250mg Vial ☐ *Enroll in Orencia On Call™*	**Infusion: Adults and pediatrics weighing 75kg or more** ☐ **Infuse** 500mg at weeks 0, 2, 4 then every 4 weeks thereafter (< 60 kg) ☐ **Infuse** 750mg at weeks 0, 2, 4 then every 4 weeks thereafter (60 to < 100 kg) ☐ **Infuse** 1000mg at weeks 0, 2, 4 then every 4 weeks thereafter (≥ 120 kg) **Infusion: Pediatrics weighing less than 75 kg** ☐ **Infuse** Infuse _____mg (10mg/kg) at weeks 0, 2, 4, then every 4 weeks thereafter **Subcutaneous injections: Adults** ☐ **Inject** 125mg subcutaneously once a week **Subcutaneous injections: Pediatrics** ☐ **Inject** 50mg subcutaneously weekly (10kg to < 25kg) ☐ **Inject** 87.5mg subcutaneously weekly (25kg to <50kg) ☐ **Inject** 125mg subcutaneously weekly (≥50kg)	4 Week Supply	_____
☐ **Otezla®** *(apremilast)* ☐ Starter Pack ☐ 30mg Tablet ☐ *Enroll in Otezla SupportPlus™*	☐ **Take** 1 tablet on day 1 and as directed in the box. Starter Pack provided on date _____ ☐ **Take** 1 tablet by mouth twice daily For Bridge Requests please utilize the *Otezla Support Plus Start Form* and fax to: **888-201-9023**	1 Starter Pack 60 Tablets	0 _____
☐ **Otrexup®** ☐ **Rasuvo** *(methotrexate)* ☐ 7.5mg ☐ 10mg ☐ 12.5mg ☐ 15mg ☐ 17.5mg ☐ 20mg ☐ 22.5mg ☐ 25mg ☐ 30mg ☐ *Enroll in CORE Connections*	☐ Single-dose auto-injector ☐ **Inject** ____mg subcutaneously once weekly	_____ _____	_____ _____
☐ **Prolia®** *(denosumab)* ☐ 60mg PFS ☐ *Enroll in ProliaPlus®*	☐ **Inject** 60mg subcutaneously every 6 months	1 PFS	_____
☐ **Reclast®** *(zoledronic acid)* ☐ 5mg/100ml Vial ☐ *Enroll in Novartis Pt Assist.*	☐ **Infuse** 5mg IV once yearly	1 Vial	_____
☐ **Remicade®** *(infliximab)* Patient Weight _____ kg ☐ 100mg vial ☐ *Enroll in Janssen CarePath*	☐ **Load**: Infuse _____ mg (_____ mg/kg) intravenously at weeks 0, 2, and 6 ☐ **Maintenance**: Infuse _____ mg (_____ mg/kg) intravenously every 8 weeks ☐ **Rheum Arthritis & Psoriatic Arthritis Maintenance**: Infuse _____ mg (_____ mg/kg) intravenously every 8 wks ☐ **Ankylosing Spondylitis Maintenance**: Infuse _____ mg (_____ mg/kg) intravenously every 6weeks	Loading Dose 8 Week Supply	0 _____
☐ **Rinvoq™** *(upadacitinib)* ☐ 15mg Ext Release Tablet ☐ *Enroll in myAbbVie Assist*	☐ **Take** 1 tablet by mouth daily	30 Tablets	_____
☐ **Rituxan®** *(rituximab)* ☐ 100mg/10ml vial ☐ 500mg/50ml Vial ☐ *Enroll in Genentech Access Solutions*	☐ **Infuse** 1000mg intravenously on days 1 and 15, repeat cycle in ___ weeks	4 x 500mg Vials ____ 100mg Vials	_____ _____
☐ **Simponi®** *(brodalumab)* ☐ 50mg/.5ml PFS ☐ 50mg /.5ml SmartJect® ☐ 50mg/4ml (12.5mg/ml) Aria® Vial ☐ *Enroll in SimponiOne®*	☐ **Inject** 50mg subcutaneously once a month ☐ **Load**: **Infuse** _____ mg (2mg/kg) at weeks 0 and 4, then every 8 weeks thereafter ☐ **Maintenance**: Infuse _____ mg (2mg/kg) every 8 weeks	4 Week Supply Loading Dose 8 Week Supply	_____ 0 _____
☐ **Stelara®** *(ustekinumab)* ☐ 45mg PFS ☐ 90mg PFS ☐ *Enroll in Janssen CarePath*	☐ **Starter**: Inject 1 syringe subcutaneously on week 0 ☐ **Maintenance**: Inject 1 syringe subcutaneously on week 4, and then every 12 weeks thereafter <100kg(220 lbs) ☐ **Inject** 45 mg subcutaneously >100kg(220 lbs) ☐ **Inject** 90 mg subcutaneously	1 Syringe 1 Syringe 1 Syringe 1 Syringe	0 _____ _____ _____
☐ **Taltz™** *(ixekizumab)* ☐ 80mg Autoinjector ☐ 80mg PFS ☐ *Enroll in Taltz Together™*	☐ **Load**: Inject 160mg (two-80mg injections) subcutaneously on day 1 ☐ **Maintenance**: Inject 80mg subcutaneously every 4 weeks	Loading Dose 4 Week Supply	0 _____
☐ **Tymlos** *(abaloparatide)* ☐ 1.56 mL PF Multi-Dose Pen ☐ *Enroll in Together with Tymlos*	☐ **Inject** 80mcg subcutaneously once a day ☐ 31G x 5mm Pen Needles use as directed with Tymlos pen	1 pen (30 days) 100 (1 box)	_____ _____
☐ **Xeljanz®** *(tofacitinib)* ☐ 5mg Tablet ☐ 11mg XR Tablet ☐ *Enroll in XELSOURCE ™*	☐ **Take** 1 tablet by mouth twice daily ☐ **Take** 1 tablet by mouth daily	60 Tablets 30 Tablets	_____ _____
☐ **Other** _____	**SIG** _____		

Prescriber's Signature (*no stamps*) _____ ☐ **Dispense as Written** **Date** _____

By signing above, I authorize GOLDEN HEALTHCARE SPECIALTY PHARMACY and its representatives to act as an agent to initiate and execute the insurance prior authorization process.