VERBAL ORDER FORM
RHEUMATOLOGY

PFSP
@pfsprx #pfsprx

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Today's Date _____
Date Needed _____

ACHC ACCREDITED
urac ACCREDITED Specialty Pharmacy Expires 07/01/2023
urac ACCREDITED Rare Disease Pharmacy Center of Excellence Expires 07/01/2023

☐ Phone Order
Ship to Patient: ☐ Home ☐ Work
Ship to: ☐ Physician Office ☐ Nurse / Training ☐ PFSP Pharmacy

Patient Name_____ Date of Birth_____ ☐ Male ☐ Female
Address_____ Apt #_____ City_____ State_____ Zip_____
Telephone_____ Cell_____ SSN_____ Email_____
Allergies_____ Comorbidities_____
Current Medications (if necessary, please fax a complete list)_____

Primary Insurance_____ ID#_____ Group #_____
Insured's Name_____ Employer_____
City_____ State_____ Phone_____

ICD-10 Diagnosis Code: ☐ L40.59 Psoriatic Arthritis ☐ M32.10 SLE ☐ M06.9 Rheumatoid Arthritis ☐ M45.9 Ankylosing Spondylitis ☐ M35.2 - Behçet's Disease ☐ M19.90 Osteoarthritis, unspecified site ☐ M81.0 Age-related osteoporosis w/o current fracture ☐ Other _____
Previously treated for this condition? ☐ Yes ☐ No Medication(s) failed _____
Patient currently taking Methotrexate? ☐ Yes ☐ No For Humira/Enbrel: PPD (TB Test) Results_____ Date_____ Total Swollen Joints_____
Rheumatoid Factor Positive_____ For Forteo: T-Score_____ Date_____ Fracture History: Site_____ Date_____

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

☐ **HUMIRA® PEN** 40mg/0.8 mL ☐ **HUMIRA® PFS** 40mg/0.8 mL
☐ **HUMIRA® Citrate-Free PEN** 40mg/0.4 mL ☐ **HUMIRA® Citrate-Free PFS** 40mg/0.4 mL
SIG: ☐ Inject 40mg SQ every OTHER week | ☐ Inject 40mg SQ ONCE a week
QTY: _____ Refill: _____ ☐ If applicable, enroll patient in *Ambassador Program*

ENBREL® ☐ SureClick™ Autoinjector 50mg ☐ PFS 25mg ☐ PFS 50mg
☐ Multiuse Vial 25mg *(injection supplies included)* ☐ Enbrel Mini™/AutoTouch 50mg
SIG: ☐ 50mg once weekly ☐ 25mg twice weekly QTY: 4 week supply Refill: _____
☐ If applicable, enroll patient in *ENBREL Support™*

CIMZIA® ☐ 200mg/1ml PFS ☐ PFS Starter Kit ☐ If applicable, enroll patient in *CIMplicity®*
☐ Initial Dose: Inject 400mg SQ on day 1, at week 2 & at week 4
☐ Maintenance Dose: Inject 200mg SQ every OTHER week QTY: _____ Refill: _____
☐ Maintenance Dose: Inject 400mg SQ every 4 weeks QTY: _____ Refill: _____
☐ Other_____ QTY: _____ Refill: _____

SIMPONI® ☐ SmartJect™ PEN 50mg/0.5mL ☐ PFS 50mg/0.5mL
☐ Inject 50mg subcutaneously once per month QTY: 1 month supply Refills: _____

SIMPONI ARIA™ ☐ 50mg/4ml (12.5mg/ml) in a single use vial
☐ Inject 2mg/kg intravenous infusion over 30 minutes at weeks 0 and 4, then every 8 weeks
Patient Weight (kg): _____ QTY: _____ # of vials Refills: _____
☐ If applicable, enroll patient in *SimponiOne®*

REMICADE® 100mg Vial **Dose:** ☐ 5mg/kg ☐ _____mg/kg *Patient Weight (kg):* _____
☐ IV on weeks 0, 2 and 6 (Induction) QTY: _____ # of vials Refills: 0
☐ IV every 8 weeks (Maintenance Dose) QTY: _____ # of vials Refills: ____
☐ IV every _____ weeks QTY: _____ # of vials Refills: ____
☐ If applicable, enroll patient in *Janssen CarePath*

TYMLOS™ ☐ 1.56 mL Prefilled Multi-Dose Pen QTY: 1 pen (30 day supply) Refill: _____
☐ Inject 80mcg subcutaneously once a day ☐ If applicable, enroll patient in *Together with Tymlos*

FORTEO® 600mcg/2.4ml Pen ☐ If applicable, enroll patient in *FORTEO Connect*
☐ Inject 20mcg subcutaneously Daily as directed QTY: 4 week supply Refill: _____
☐ BD - 31G x 5mm PEN NEEDLES *use as directed w/Forteo pen* QTY: 100 (1 box) Refill: _____

PROLIA® ☐ 60mg PFS ☐ If applicable, enroll patient in *ProliaPlus®*
☐ Inject 60mg subcutaneously every 6 months QTY: 1 Refill: _____

RECLAST® ☐ 5mg/100ml Vial ☐ 5mg IV once yearly QTY: 1 Refill: _____

EVENITY ☐ 105mg/1.17mL PFS (2-count)
☐ Inject 210mg (2-105mg PFS) under the skin once monthly for 12 months
QTY: ☐ 2 PFS (1 month) ☐ 6 PFS (3 months) Refill: _____

OTEZLA® ☐ Prescriber provided Two-Week Starter Pack on _____
Starter: ☐ 28 Day Starter Pack SIG: Take as directed QTY: 55 Refill: 0
☐ 30mg twice daily (recommended) ☐ 30mg daily (for severe renal impairment)
Maintenance: ☐ SIG: Take one tablet by mouth twice daily QTY: 60 Refill: ____
☐ SIG: Take one tablet by mouth daily QTY: 30 Refill: ____
☐ If applicable, enroll in *Otezla SupportPlus™* ☐ If applicable, enroll in *Bridge RX Program*

COSENTYX® ☐ 150 mg Sensoready® Pen ☐ 150 mg PFS ☐ If applicable, enroll patient in *Cosentyx® Connect*
☐ **Starting Dose:** Weeks 0, 1, 2, 3, and 4, then once every 4 weeks
SIG: ☐ Inject 150 mg dose SQ once weekly for 5 weeks. QTY: 5 injection devices Refills: 0
☐ _____ mg dose SQ once weekly for 5 weeks. QTY: 10 injection devices Refills: 0
Each 300 mg dose is given as 2 SQ injections of 150 mg.
☐ **Maintenance Supply:** Once every 4 weeks
SIG: ☐ Inject 150 mg dose SQ once every 4 weeks QTY: _____ Refills: _____
☐ Inject 300 mg dose SQ once every 4 weeks QTY: _____ Refills: _____
Each 300 mg dose is given as 2 SQ injections of 150 mg.

BENLYSTA® ☐ 120mg Vial ☐ 400mg Vial *Patient Weight (kg):* _____
☐ Induction Dose: Inject 10mg/kg SQ every 2 weeks for first 3 doses
☐ Maintenance Dose: Inject 10mg/kg SQ every 4 weeks
QTY: _____# of vials Refill: _____ ☐ If applicable, enroll patient in *BENLYSTA Connects*

☐ **RINVOQ™** 15mg tablet SIG: Take one tablet by mouth once daily QTY: 30 Refill: _____
☐ **OLUMIANT®** 2mg tablet SIG: Take one tablet by mouth once daily QTY: 30 Refill: _____
☐ **XELJANZ®** 5mg tablet SIG: Take one tablet by mouth twice daily QTY: 60 Refill: _____
☐ **XELJANZ XR®** 11mg tablet SIG: Take one tablet by mouth once daily QTY: 30 Refill: _____
If applicable, enroll patient in ☐ *myAbbVie Assist* (Rinvoq) ☐ *Lilly Cares* (Olumiant) ☐ *XELSOURCE℠*

☐ **DUEXIS** (ibuporofen 800mg/famotidine 26.6mg) tablet
☐ SIG: Take 1 tablet by mouth three times daily QTY: 90 Refill: _____
☐ **RAYOS** ☐ 1mg ☐ 2mg ☐ 5mg SIG: _____ QTY: _____ Refill: _____
☐ **PENNSAID 2% SOLUTION** 112g pump bottle
☐ SIG: Apply 2 pumps to the affected joint twice daily QTY: _____ Refill: _____
☐ **RELAFEN DS** 1000mg tablet
☐ SIG: 1 PO QD QTY: 30 Refill: _____ ☐ SIG: 1 PO BID QTY: 60 Refill: _____

KEVZARA® ☐ 200 mg/1.14 mL | ☐ 150 mg/1.14 mL ☐ Pre-filled Pens ☐ Pre-filled Syringes
Dispense: ☐ Inject 150 mg subcutaneously every other week QTY: 2 Refill: _____
☐ Inject 200 mg subcutaneously every other week QTY: 2 Refill: _____
ANC_____ Platelets_____ Liver Function Tests_____
☐ If applicable, enroll patient in *KevzaraConnect®*

ACTEMRA ☐ ACTPen 162mg/0.9mL ☐ PFS 162mg/0.9mL ☐ Vial 400mg/20mL
Dosing: ☐ < 100kg: Inject 162mg once every other week QTY: _____ Refills: _____
☐ ≥ 100kg: Inject 162mg once every week QTY: _____ Refills: _____
☐ IV: Infuse 4mg/kg IV once every four weeks QTY: _____ Refills: _____
☐ Other: _____ QTY: _____ Refills: _____
☐ If applicable, enroll in *Actemra Access Solutions*

☐ **METHOTREXATE TABS** ☐ **RASUVO** ☐ **OTREXUP** ☐ If applicable, enroll patient in *CORE Connections*
☐ SQ: Inject ____mg SQ once weekly QTY: _____ Refill: _____
☐ Oral: Take ____mg by mouth once weekly QTY: _____ Refill: _____
☐ Other: _____ QTY: _____ Refill: _____

KINERET® 100mg/0.67 mL PFS ☐ If applicable, enroll patient in *KINERET On TRACK*
☐ Inject 100mg (0.67ml) SQ QD QTY: 4 week supply Refill: _____

ORENCIA® *Carton of 4 autoinjectors*: ☐ 125mg PFS ☐ 250mg Vial ☐ 125mg ClickJect™
☐ Inject 125mg SQ weekly
☐ < 60kg Infuse 500mg at weeks 0, 2 and 4, then every 4 weeks thereafter
☐ 60 - 100kg Infuse 750mg at weeks 0, 2 and 4, then every 4 weeks thereafter
☐ > 100kg Infuse 1000mg at weeks 0, 2 and 4, then every 4 weeks thereafter
☐ Other: _____
QTY: 4 week supply Refill: _____ ☐ If applicable, enroll patient in *ORENCIA On Call™*

RITUXAN® ☐ 100mg/10ml Vial ☐ 500mg/50ml Vial QTY: _____# of vials Refill: _____
☐ Infuse 1000mg on day 1 and day 15, repeat course every 24 weeks
☐ Other: _____

STELARA™ ☐ 45mg PFS ☐ 90mg PFS *Patient Weight (kg):* _____
☐ For patients <100kg (220lbs):Inject 45mg SQ initially & 4 weeks later, followed by 45mg every 12 weeks.
☐ For patients >100kg (220lbs): Inject 90mg SQ initially & 4 weeks later, followed by 90 mg every 12 weeks
☐ Other: _____ QTY: _____ Refill: _____
☐ If applicable, enroll patient in *Janssen CarePath*

TALTZ® 80mg ☐ Autoinjector ☐ Prefilled Syringe
☐ Starting Dose: Inject 160mg SQ at week 0 followed by 80mg at week 4
☐ Maintenance Dose: Inject 80mg SQ every 4 weeks QTY: _____ Refills: _____
☐ Sharps Container ☐ If applicable, enroll patient in *Taltz Together™*

OTHER _____
SIG_____ QTY: _____ Refill: _____

Prescriber's Name / Practice _____ Office Contact_____
Address_____ Suite#_____ City_____ State_____ Zip_____
Tel_____ Fax_____ Email_____
License#_____ NPI#_____ UPIN#_____ DEA#_____
Prescriber's Signature (signature required. NO STAMPS)_____ **Date**_____

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Scan our QR Code to send us feedback about your experience.