

1 PATIENT INFORMATION		2 INSURANCE INFORMATION
Today's Date: _____ Need By Date: _____ Ship To: <input type="checkbox"/> Patient <input type="checkbox"/> Dr. office <input type="checkbox"/> _____	Patient Name: _____ Date of Birth: _____ SSN: _____ Address: _____ City, State, Zip Code: _____ Phone: _____ Email Address: _____ Preferred language: _____ Contact Person: _____	PLEASE FAX A COPY (FRONT AND BACK) OF PATIENT'S CURRENT ACTIVE INSURANCE AND ID CARDS. FOR PATIENTS WITH BOTH MEDICARE AND MEDI-CAL, PLEASE FAX IN COPIES FOR BOTH.
3 SPECIAL INSTRUCTION		
Training: <input type="checkbox"/> Pharmacy will coordinate training for patient <input type="checkbox"/> Provider will provide training <input type="checkbox"/> Training not necessary		Delivery: _____ _____

4 CLINICAL INFORMATION

PLEASE FAX COPIES OF RECENT CHART NOTES, LABS, EVIDENCE OF DIAGNOSIS, AND CURRENT MEDICATION LIST.

5 DIAGNOSIS AND CLINICAL INFORMATION

Diagnosis (ICD-9 or ICD-10) _____ Date of Diagnosis _____

M06.9 Rheumatoid Arthritis
 M08.0 Juvenile Idiopathic Arthritis
 L40.59 Psoriatic Arthritis
 L40.54 Psoriatic Juvenile Arthritis
 M45.9 Ankylosing Spondylitis
 Other: _____

Has patient had positive TB test? Yes No If yes, date of last chest x-ray: _____

Height: _____ Weight: _____ Allergies: _____

Previously Tried/Failed Medications-include dosage and frequency	Date of Trial	Reason for Discontinuation

6 PRESCRIPTION INFORMATION

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
<input type="checkbox"/> Actemra®	<input type="checkbox"/> 162 mg/0.9 mL Prefilled Syringe	<input type="checkbox"/> <100 kg: SQ every other week; increase to every week based on clinical response <input type="checkbox"/> ≥100 kg: SQ 162 mg every week <input type="checkbox"/> Other: _____	1 kit	
<input type="checkbox"/> Cimzia	<input type="checkbox"/> Cimzia Starter Kit <input type="checkbox"/> 200mg/1 mL Prefilled Syringe <input type="checkbox"/> 200mg vial	<input type="checkbox"/> Induction Dose: Inject 400mg subcutaneously on day 1, at week 2, and at week 4. <input type="checkbox"/> Maint. Dose: Inject 200mg subcutaneously every OTHER week. <input type="checkbox"/> Maint. Dose: Inject 400mg subcutaneously every 4 weeks. <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Cosentyx®	<input type="checkbox"/> 150 mg/mL Sensorady Pen <input type="checkbox"/> 150 mg/mL Prefilled Syringe <input type="checkbox"/> 150 mg vial	<input type="checkbox"/> 300 mg sq at weeks 0,1,2,3, and 4, then 300 mg every 4 weeks <input type="checkbox"/> 150 mg sq at weeks 0,1,2,3, and 4, then 150 mg every 4 weeks <input type="checkbox"/> 150 mg sq every 4 weeks		
<input type="checkbox"/> Enbrel®*	<input type="checkbox"/> 50mg/ml Sureclick <input type="checkbox"/> 50mg/ml Prefilled Syringe <input type="checkbox"/> 25mg/0.5ml Prefilled Syringe <input type="checkbox"/> 25mg Vial	<input type="checkbox"/> Inject 50mg subcutaneously ONCE a week. <input type="checkbox"/> Inject 25mg subcutaneously TWICE a week (72-96 hours apart). <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Humira®*	<input type="checkbox"/> 40mg/0.8ml Pen <input type="checkbox"/> 40mg/0.8ml Prefilled Syringe <input type="checkbox"/> 20mg/0.4ml Prefilled Syringe	<input type="checkbox"/> Inject 40mg subcutaneously every OTHER week. <input type="checkbox"/> Inject 20mg subcutaneously every OTHER week. <input type="checkbox"/> Inject 40 mg subcutaneously every week <input type="checkbox"/> Other: _____	<input type="checkbox"/> 1 carton (2 pens or PFS) <input type="checkbox"/> 2 cartons (4 pens or PFS) Other: _____	
<input type="checkbox"/> Kineret®	<input type="checkbox"/> 100mg Prefilled Syringe	<input type="checkbox"/> Inject 100mg (one syringe) SC once a day.		
<input type="checkbox"/> Orencia®	<input type="checkbox"/> 125 mg Orencia Subcutaneous	<input type="checkbox"/> After single IV loading dose, inject 125mg subcutaneously within a day followed by 125mg subcutaneous injections every week thereafter <input type="checkbox"/> For patients unable to receive an IV loading dose, inject 125mg subcutaneously every week <input type="checkbox"/> For patients transitioning from IV infusion therapy to subcutaneous therapy, inject 125mg subcutaneously instead of the next scheduled IV dose followed by 125mg subcutaneous injections every week thereafter <input type="checkbox"/> Inject 125mg subcutaneously every week		
<input type="checkbox"/> Otezla®	<input type="checkbox"/> 28-day Starter Pack <input type="checkbox"/> Maintenance	<input type="checkbox"/> As directed on packaging <input type="checkbox"/> Take 30 mg by mouth twice daily	<input type="checkbox"/> 55 tablets (one 28-day pack) <input type="checkbox"/> 60 tablets <input type="checkbox"/> Other: _____	
<input type="checkbox"/> Simponi®	<input type="checkbox"/> 50mg/0.5ml Prefilled SmartJect Autoinjector <input type="checkbox"/> 50mg/0.5ml Prefilled Syringe	<input type="checkbox"/> Inject 50mg (0.5ml) subcutaneously once a month <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Stelara®	<input type="checkbox"/> Injection 45 mg/0.5 mL in a single-use prefilled syringe <input type="checkbox"/> Injection: 90 mg/mL in a single-use prefilled syringe	<input type="checkbox"/> The recommended dose is 45 mg SQ initially and 4 weeks later, followed by 45 mg SQ every 12 weeks. For patients with co-existent moderate-to-severe plaque psoriasis weighing >100 kg (220 lbs), the recommended dose is 90 mg initially and 4 weeks later, followed by 90 mg every 12 weeks		
<input type="checkbox"/> Xeljanz®	<input type="checkbox"/> 5mg	<input type="checkbox"/> Take one 5mg tablet PO twice daily <input type="checkbox"/> Other: _____	<input type="checkbox"/> 60 <input type="checkbox"/> 120 <input type="checkbox"/> 180	

7 PROVIDER AUTHORIZATION & INFORMATION

By signing below, the prescriber gives consent to both, the prescription(s) above, as well as to Dolphin Health to act as the prescriber's agent to begin and To execute the prior authorization process and to help the patient apply to co-pay assistance programs, including all foundations and manufacturer assistance programs if necessary.

<input type="checkbox"/> Prescriber Name: _____	DEA: _____	NPI: _____	<input type="checkbox"/> Prescriber Name: _____	DEA: _____	NPI: _____
<input type="checkbox"/> Prescriber Name: _____	DEA: _____	NPI: _____	<input type="checkbox"/> Prescriber Name: _____	DEA: _____	NPI: _____
<input type="checkbox"/> Prescriber Name: _____	DEA: _____	NPI: _____	<input type="checkbox"/> Prescriber Name: _____	DEA: _____	NPI: _____

Address: _____ Phone: _____ Fax: _____ Contact Person: _____

Date: _____ **Provider Signature:** _____ **Do not substitute**