MOUNTAINVIEW PHARMACY

Where we deliver care...

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RA

Must Be Filled Out

❑ New Patient ❑ Current	Injection Training Needed ❑ Date
Patient's Name	Tax ID #
D.O.B. ❑ Male ❑ Female Last 4 digits of SSN	Prescriber's Name and Title
Street Address Apt #	Street Address Suite #
City State Zip	City State Zip
Home Phone Cell Phone	Phone Fax
E-mail Address	NPI #
Insurance Bin/PCN/Grp/ID	DEA #
Insured's Name	
Relationship to Patient	
Does Patient have a secondary insurance? ❑ Yes ❑ No	
Allergies	

Diagnosis/Clinical Information

Diagnosis: ICD-10:	**BMD/T-score:** **Date:**
Prior failed medication (medication and duration of treatment/reason for d/c):	**Does patient have a latex allergy?** ❑ Yes ❑ No
❑	**Is patient at risk for osteoporotic fracture as evident by any of the following?**
❑	❑ History of osteoporotic fracture Site: Date:
Is Patient currently on RA therapy? ❑ Yes ❑ No	❑ Patient has tried and failed an oral bisphosphonate
Medications:	❑ Patient has documented contraindications/is intolerant to oral bisphosphonate therapy (please submit a copy of DEXA w/prescription)
TB/PPD Test Given? ❑ Yes ❑ No	

Prescription Information

Medication	Dose / Strength	Sig	Qty
❑ Actemra	❑ 162mg/0.9mL PFS	❑ Inject 162mg SC (pt<100kg) every other week, followed by an increase to every week based on clinical response. ❑ Inject 162mg SC (pt>100kg) every week.	
❑ Cimzia	❑ Prefilled syringes (2x200mg) ❑ Lyophilized vials (2x200mg)	❑ **RA/PsA:** Inject 400mg SC at weeks 0, 2 and 4 followed by 200mg every other week or 400mg every 4 weeks. ❑ **Ank Spon:** Inject 400mg SC at 0, 2 and 4 followed by 200mg every other week or 400mg every 4 weeks.	
❑ Cosentyx	❑ 150mg/mL	❑ **PsA/Ank Spon:** Inject 150mg SC at weeks 0, 1, 2, 3, & 4 and every 4 weeks thereafter. ❑ **PsA/Ank Spon:** Inject 150mg SC every 4 weeks.	
❑ Enbrel	❑ 25mg/0.5ml PFS ❑ 25mg/ml Vial ❑ 50mg/ml Pen ❑ 50mg/ml PFS	❑ **RA/PsA/Ank Spon:** Inject 50mg SC once a week	
❑ Humira	❑ 40mg Pen ❑ 40mg PFS	❑ **RA/PsA/Ank Spon:** Inject 40mg SC every other week	
❑ Kevzara	❑ 150mg/1.14mL ❑ 200mg/1.14mL	❑ Inject 200mg SC once every 2 weeks ❑ Inject 150mg SC once every 2 weeks	
❑ Orencia	❑ 125mg/mL PFS ❑ 125mg/mL Pen	❑ Inject 125mg SC once every a week	
❑ Otrexup	❑ 7.5mg/0.4mL	❑ Inject 7.5mg once a week	
❑ Otezla	❑ 28-day starter pack 30mg	❑ Take as directed on starter pack. ❑ Take 1 tablet by mouth twice a day.	
❑ Rasuvo	❑ 20mg/0.4mL Pen	❑ Inject 20mg once a week	
❑ Remicade Pt Weight:_____	❑ 100mg Vial		
❑ Simponi	❑ 50mg SmartJect ❑ 50mg PFS	❑ **RA/PsA/Ank Spon:** Inject 50mg SC once a month	
❑ Stelara	❑ 45mg/0.5mL PFS	❑ **Induction Dose:** Inject 45mg SC at week 0 and 4. ❑ **Maintenance Dose:** Inject 45mg SC every 12 weeks thereafter.	
❑ Xeljanz	❑ 5mg	❑ Take 1 tablet by mouth twice a day	
❑ Xeljanz XR	❑ 11mg	❑ Take 1 tablet by mouth once a day	

I authorize Mountainview Pharmacy, Inc and its representative to act as my agent to initiate and execute insurance prior authorization process for this script and any future fills of the same script for the patient listed above and to sign any forms necessary on my behalf as an authorized agent. I understand I can revoke this designation at any time .

Physician Office Contact:	Name:	Email:
	Phone:	Fax:
Physician Signature:		Date: