Rheumatoid Arthritis
Prescription & Pharmacy Intake Form

Phone: 1-718-762-7400
Fax: 1-718-762-7404
Toll Free: 1-888-93-EVERS

Provider Representative | **Phone** **Date Needed** **Ship to** ☐ Specialty Care Center ☐ Patient's Home ☐ Prescriber's Office ☐Other______________

PATIENT INFORMATION

Patient Name:____________________ DOB: __________ ☐ Male ☐ Female
Address: ______________________________
City: ______________ State: ______ Zip Code:__________
Phone # (Daytime): ______________ Phone # (Evening): ______________
E-mail Address: ______________________ Case Manager: __________
Insurance Provider (**Please include copy of front and back of card**): ______________
ID #: __________ Policy/Group #: __________ Phone #: __________
Name of Insured: ______________ Employer: __________
Relationship to Patient: ☐ Self ☐ Other: __________ ☐ Patient is Eligible for Medicare
Prescription Card: ☐ Yes ☐ No Carrier: __________ Policy/Group #: __________
Will there be access to anaphylactic medications and oxygen at the administration site? __________

CLINICAL ASSESSMENT

☐ Patient is New to Therapy
☐ Patient is Currently on Therapy
(Start Date: __________)
☐ Physician Provides Injection Training
Injection/Infusion Date: __________

Primary ICD-9 Code and Condition:
____

Other ICD-9/Conditions:
____

Joints Affected:__________
Number of Tender Joints: ______
Number of Swollen Joints: ______
Current Weight:________ Date: ______

☐ New Therapy Induction | Stop Date:______
☐ Therapy Change | Stop Date:______
☐ Therapy Continuation | Stop Date:______
Weeks Completed ☐ 0 ☐ 2 ☐ 4 ☐ 6

ESR & Date:______________
CRP & Date:______________
TB Results & Date:______________
Allergies:______________

Medication	Dose/Directions/Freq	Qty	Refills
Actemra® (tocilizumab) ☐ 80 mg/4 mL Vial ☐ 200 mg/10 mL Vial ☐ 400 mg/20 mL Vial			
Cimzia® (certolizumab pegol) ☐ 2 x 200 mg kit ☐ Syringe ☐Vial			
Enbrel® (etanercept) ☐ 25 mg Syringe ☐25 mg Vial ☐ 50 mg Syringe ☐50 mg SureClick™ Pen			
Humira® (adalimumab) ☐ 20 mg Syringe ☐ 40 mg Syringe ☐40 mg Pen			
Kineret® (anakinra) ☐ 100 mg Syringe			
Orencia® (abatacept) ☐ (4) 125 mg Prefilled Syringe ☐ 250 mg Vial			
Remicade® (infliximab) ☐ 100 mg Vial			
Rituxan® (rituximab) ☐ 100 mg Vial ☐ 500 mg Vial			
Simponi® (golimumab) ☐ 50 mg Syringe ☐50 mg Smartject			
Methotrexate - Can only be ordered as combined therapy with one of above drugs			
☐ 2.5 mg Tablet			
☐ Other ______________			

PRESCRIBER INFORMATION

Prescriber's Name:______________ Practice/Facility Name: ______________
Address:______________________ Office Contact: ______________
City:__________ State:______ Zip Code: __________
Phone #:__________ Fax:__________ Best Time to Call: __________
State License #:__________ DEA #:__________ NPI#:__________ Medicaid UPIN #: __________
In order for a brand name product to be dispensed, the prescriber must handwrite "**Brand Necessary**" or "**Brand Medically Necessary**," or your state speci c required language to prohibit substitution: ______________
I certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge.
Prescriber's Signature Required:______________________ Date:__________

CONFIDENTIAL HEALTH INFORMATION: Healthcare information is personal information related to a person's healthcare. It is being faxed to you after appropriate authorization or under circumstances that don't require authorization. You are obligated to maintain it in a safe, secure and confidential manner. Re-disclosure of this information is prohibited unless permitted by law or appropriate customer/patient authorization is obtained. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state laws.
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Drug names are the property of their respective owners.