RHEUMATOID ARTHRITIS PRESCRIPTION FORM (Part 2)

Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy.
Prescribers are reminded patients may choose any pharmacy of their choice.

Owl Specialty Pharmacy
1010 E. Arrow Hwy., Covina, CA 91724
Phone: 626-209-8169 Fax: 626-209-8171 or 855-817-9523
www.owlspecialty.com

Patient Information: please provide a copy of the patient's insurance card or information				
Patient Name:	**DOB:**	**Gender:** ☐ F ☐ M	**HT:**	**WT:**
Address:	**City:**	**State:**	**Zip Code:**	**Phone:**
Insurance:	**Subscriber's name:**	**ID#:**	**Group #:**	
Allergies: ☐ NKDA ☐ List allergies:				

Clinical Diagnosis: please fax or email relevant clinical notes, labs, tests and previous medical history to expedite prior authorization			
Diagnosis / ICD-10:	**Date of Diagnosis or Years with Disease:**	☐ **Mild** ☐ **Moderate** ☐ **Severe**	
Has patient been previously treated for this condition? ☐ Yes ☐	**Is patient currently on therapy?** ☐ Yes ☐ No	**Will patient terminate current therapy upon start of new prescription?** ☐ Yes ☐ No	
Previous Therapy (dates):			
Is the patient taking methotrexate? ☐ Yes ☐ No	**Latex allergy:** ☐ Yes ☐ No	**BMD/T-Site & Score & Date:**	**TB/PPD Test:** ☐ **Yes** ☐ **No** **Results:**

Medication	**Dose / Strength**	**Directions**	**Quantity**	**Refills**
☐ **Olumiant**	☐ 2 mg tablets	☐ Take one tablet once daily		
☐ **Orencia**	☐ 125 mg/mL prefilled syringe (4) ☐ 125 mg/mL ClickJect™ Autoinjector ☐ 250 mg/15 mL vial (IV only)	☐ Inject 125 mg SC once weekly ☐ Infuse_______mg IV every 4 weeks	_______ syringes _______ vials	
☐ **Otezla**	☐ Starter Pack ☐ 30 mg tablets	☐ Take as directed ☐ Take 1 tablet twice daily	☐ 1 pack (2 week supply) ☐ 60 tablets	
☐ **Otrexup**	Single-dose auto-injector ☐ 7.5 mg ☐ 10 mg ☐ 12.5 mg ☐ 15 mg ☐ 17.5 mg ☐ 20 mg ☐ 22.5 mg ☐ 25 mg	☐ ______ mg SC once weekly		
☐ **Rasuvo**	Single-dose manually-triggered auto-injector ☐ 7.5 mg ☐ 10 mg ☐ 12.5 mg ☐ 15 mg ☐ 17.5 mg ☐ 20 mg ☐ 22.5 mg ☐ 25 mg ☐ 27.5 mg ☐ 30 mg	☐ _______ mg SC once weekly		
☐ **Remicade**	☐ 100 mg/20 ml vial			
☐ **Rinvoq**	☐ 15 mg extended-release tablets	☐ Take 15 mg PO once daily		
☐ **Rituxan**	☐ 10 mg/ml			
☐ **Simponi**	☐ 50 mg/0.5 ml Prefilled Syringe ☐ 50 mg/0.5 ml Autoinjector	☐ Inject 50 mg SC once a month	4 week supply	
☐ **Stelara**	☐ 45 mg Prefilled Syringe ☐ 90 mg Prefilled Syringe	☐ Inject SC weeks 0, 4 and every 12 weeks thereafter	4 week supply	
☐ **Supartz**	☐ 25 mg Prefilled Syringe	☐ Inject 25 mg / 2.5 ml intra-articularly into knee once weekly for a total of 5 injections		
☐ **Taltz**	☐ 80 mg/mL prefilled syringe ☐ 80 mg/mL prefilled autoinjector	☐ 160 mg SC (two 80 mg injections) at Week 0, followed by 80 mg at Weeks 2, 4, 6, 8, 10, and 12, then 80 mg every 4 weeks ☐ 160 mg SC (two 80 mg injections) at Week 0, followed by 80 mg every 4 weeks.		
☐ **Tremfya**	☐ 100 mg syringe	☐ Inject 100 mg SC days 0 and 28 ☐ Inject 100 mg every 8 weeks	4 week supply	
☐ **Xeljanz**	☐ 5 mg tablets ☐ 11 mg ER tablets	☐ Take 5 mg PO twice daily ☐ Take 11 mg PO once daily	4 week supply	

Prescriber Information				
Prescriber name:	**Phone:**	**Office contact name:**		
Prescriber address:	**City:**	**State:**	**Zip:**	
NPI:	**DEA:**	**Email / Fax:**		
Signature:	**Date:**	☐ **DO NOT SUBSTITUTE**		