MAIN POINT OF CONTACT

Name: _____

Phone: _____

ALLIED PHARMACY

RHEUMATOLOGY

Ph: 832-365-3420 Fax: 855-595-2955

Injection Training: ☐ MD Office ☐ Pharmacy to Arrange

Ship To : ☐ Patient Home ☐ MD Office

PATIENT INFORMATION (Use this area or attach patient demographics)

Name:_____ Phone:_____ Phone 2:_____

Home Address:_____ City:_____ State:_____ Zip Code:_____

DOB:_____ SSN:_____ Sex: ☐ Male ☐ Female Height:_____

Weight:_____lbs. Emergency Contact:_____

Phone:_____

INSURANCE INFORMATION (Use this area or attach copy of insurance card(s))

Primary Insurance:			Secondary Insurance:	
ID#:	RxBin:		ID#:	RxBin:
RxGroup:	Pcn:		RxGroup:	Pcn:

MEDICAL ASSESSMENT (Use this area or attach patient labs and other authorization information)

Primary Diagnosis:_____ ICD10 Code:_____

PRESCRIPTION INFORMATION *(Use this area or attach copy of RX(s))

MEDICATION	DOSE	DIRECTIONS	QTY	REFILLS
☐ ACTEMRA	☐ 162mg/0.9ml PFS ☐ 162mg/0.9ml Pen Autoinjector	☐ INJECT 162MG SQ ONCE EVERY WEEK ☐ INJECT 162MG SQ ONCE EVERY OTHER WEEK	[QS 4 WEEK SUPPLY]	
☐ BIMZELX	☐ 160MG PFS ☐ 160MG AUTOINJECTOR	☐ INJECT 160MG SQ ONCE EVERY 4 WEEKS	[QS 4 WEEK SUPPLY]	
☐ CIMZIA	☐ 200MG PFS ☐ 200MG SDV	☐ INJECT 400MG SQ AT WEEKS 0, 2 AND 4 ☐ INJECT 200MG SQ ONCE EVERY OTHER WEEK ☐ INJECT 400MG SQ ONCE EVERY 4 WEEKS	[QS 4 WEEK SUPPLY]	
☐ COSENTYX	☐ 75mg/0.5 mL PFS ☐ 150mg/ml PFS ☐ 150 mg/ml Pen	☐ INJECT ____MG SQ ONCE WEEKLY AT WEEKS 0, 1, 2, 3 AND 4 ☐ INJECT____MG SQ ONCE EVERY 4 WEEKS	[QS 4 WEEK SUPPLY]	
☐ ENBREL	☐ 25MG SDV ☐ 25MG PFS ☐ 50MG AUTOINJECTOR ☐ 50MG PFS ☐ 50MG MINI CARTRIDGE	☐ INJECT_____MG_____TIME(S) PER WEEK	[QS 4 WEEK SUPPLY]	

ALL controlled substance quantities must be hand written in number and letter form

Prescriber Name:_____ NPI#:_____

Address: City: State: Zip Code:

Phone: Fax:

***Prescriber Signature:** **Date:**

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PRESCRIPTION INFORMATION *(Use this area or attach copy of RX(s))

MEDICATION	DOSE	DIRECTIONS	QTY	REFILLS
☐ HUMIRA CF	☐ 10MG PFS ☐ 20MG PFS ☐ 40MG PFS ☐ 40MG PEN ☐ 80MG PEN	☐ INJECT_____MG SQ EVERY WEEK ☐ INJECT_____MG SQ EVERY OTHER WEEK	[QS 4 WEEK SUPPLY]	
☐ KEVZARA	☐ 150MG PFS ☐ 150MG AUTOINJECTOR ☐ 200MG PFS ☐ 200MG AUTOINJECTOR	☐ INJECT____MG SQ ONCE EVERY 2 WEEKS	[QS 4 WEEK SUPPLY]	
☐ OLUMIANT	☐ 1MG TABLET ☐ 2MG TABLET ☐ 4MG TABLET	☐ TAKE_____MG BY MOUTH ONCE DAILY		
☐ ORENCIA	☐ 50mg PFS ☐ 87.5mg PFS ☐ 125mg PFS ☐ 25mg ClickJect	☐ INJECT_____MG SQ EVERY WEEK	[QS 4 WEEK SUPPLY]	

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Primary Diagnosis:_____ ICD10 Code:_____

PRESCRIPTION INFORMATION *(Use this area or attach copy of RX(s))

MEDICATION	DOSE	DIRECTIONS	QTY	REFILLS
☐ OTEZLA	☐ STARTER PACK ☐ 20MG TABLET ☐ 30MG TABLET	☐ FOLLOW PACKAGE INSTRUCTIONS AND USE AS DIRECTED BY PHYSICIAN ☐ TAKE____MG BY MOUTH____TIME(S) PER DAY		
☐ RASUVO	☐ 7MG AUTOINJECTOR ☐ 10MG AUTOINJECTOR ☐ 12MG AUTOINJECTOR ☐ 15MG AUTOINJECTOR ☐ 17MG AUTOINJECTOR ☐ 20MG AUTOINJECTOR ☐ 22MG AUTOINJECTOR ☐ 25MG AUTOINJECTOR	☐ INJECT _____MG SQ ONCE WEEKLY ON THE SAME DAY EACH WEEK	4 INJECTORS	
☐ RELAFEN DS	☐ 1000MG TABLET	☐ TAKE 1 TABLET BY MOUTH_____TIME(S) PER DAY	[30] OR [60]	
☐ RINVOQ	☐ 15MG TABLET	☐ TAKE 1 TABLET BY MOUTH ONCE DAILY	[30]	
☐ SIMPONI	☐ 50MG PFS ☐ 50MG SMARTJECT	☐ INJECT 50MG SQ ONCE EVERY 4 WEEKS	[QS 4 WEEK SUPPLY]	
☐ STELARA	☐ 45MG PFS ☐ 90MG PFS	☐ INJECT___MG SQ ☐ INJECT _____MG SQ ON DAY 29 AND EVERY 12 WEEKS THEREAFTER		

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PRESCRIPTION INFORMATION *(Use this area or attach copy of RX(s))

MEDICATION	DOSE	DIRECTIONS	QTY	REFILLS
☐ TALTZ	☐ 80MG PFS ☐ 80MG AUTOINJECTOR	☐ INJECT 160MG SQ ONCE AT WEEK 0 ☐ INJECT 160MG SQ AT WEEK 0, FOLLOWED BY 80MG SQ AT WEEK 2 ☐ INJECT 80MG SQ AT WEEK 4 AND EVERY 2 WEEKS THEREAFTER THROUGH WEEK 10 ☐ INJECT 80MG SQ AT WEEK 12 AND EVERY 4 WEEKS THEREAFTER ☐ INJECT 80MG SQ EVERY 4 WEEKS	[QS 4 WEEK SUPPLY]	
☐ TREMFYA	☐ 100MG PFS ☐ 100MG AUTOINJECTOR	☐ INJECT 100MG SQ AT WEEK 0 AND WEEK 4 ☐ INJECT 100MG SUBQ ONCE EVERY 8 WEEKS		
☐ XATMEP	☐ 2.5MG/ML ORAL SOLUTION	☐ TAKE _____MG BY MOUTH ONE TIME WEEKLY	[QS 4 WEEK SUPPLY]	
☐ XELJANZ	☐ 5MG TABLET ☐ 11MG XR TABLET	☐ TAKE _____TABLET(S) BY MOUTH_____TIME(S) PER DAY	[30] OR [60]	
☐ XIFRYM	☐ 30MG/ML VIAL			

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