GREATER PLACER SPECIALTY PHARMACY

3133 PROFESSIONAL DRIVE #17 AUBURN, CA 95603
PHONE: 530-885-8582 | FAX: 530-885-8593 OR 888-696-6055 | WWW.GPRX1.COM

Date: _____

RHEUMATOLOGY PRESCRIPTION FORM

PATIENT INFORMATION

Patient Name: _____ ☐ Male ☐ Female
Address: _____ Date of Birth: _____
City, State,Zip: _____ SSN: _____
Phone: _____

Need by Date: _____

Ship to: ☐ Patient Home
☐ Other: _____

PRESCRIBER INFORMATION

Prescriber Name: _____ DEA: _____ NPI: _____
Address: _____ Phone: _____ Fax: _____
City, State, Zip: _____ Contact Person: _____

DIAGNOSIS/ CLINICAL INFORMATION

ICD-9 Code: ☐ 696.0 Psoriatic arthritis ☐ 714.0 Rheumatoid Arthritis ☐ 733.0 Osteoporosis ☐ 715.9 Osteoarthritis ☐ 720.0 Ankylosing Spondylitis ☐ _____
Date of Diagnosis/ Years with disease: _____ Try and Fail medications: _____ Tried Methotrexate: ○Yes ○No
Weight: _____lbs / kg Allergies: _____ Latex Allergy (Enbrel) : ○Yes ○No TB Test (Humira/Enbrel): _____
☐T-Score: _____ Site: _____ Date: _____ ☐Fracture History: _____ Site: _____ Date: _____
Comment:

PRESCRIPTION INFORMATION

☐**INITIAL PRESCRITION** ☐**PREVIOUSLY DISPENSED**

MEDICATIONS

MEDICATION	STRENGTH	DIRECTION	QTY	REFILLS
☐ Cimzia®	☐Starter Package (200mg) ☐200mg	☐ Initial Dose: Inject 400mg SQ at week 0,2,4 ☐Maintenance Dose: ○ Inject 400mg SQ every 4 weeks ○ Inject 200mg SQ every 2 weeks	4wk	
☐ Humira®	☐ 40mg/0.4ml PFS (2 doses)	☐ Inject 40mg SQ every ○ Once a week ○ every OTHER week	4wk	
☐ Enbrel®	☐ 50mg/ml PFS ☐ 50mg/ml Sureclick Autoinject ☐ 25mg PFS	☐ Inject 50mg SQ ONCE a week ☐ Inject 25mg SQ TWICE a week, 72 to 96 hours apart ☐ Other:	4wk	
☐ Forteo®	☐ 750mcg/3ml Pen	☐ Inject 20 mcg SQ as directed ONCE a day (dispense with 31G6mm pen needles)	4wk	
☐ Orencia®	☐125mg/ml PFS (#4)	☐ Inject 125mg SQ ONCE weekly	4wk	
☐ Simponi®	☐ 50mg/0.5ml PFS ☐ 50mg/0.5ml Autoinjector	☐ Inject 50mg ONCE a month	4wk	
☐ Prolia®	☐ 60mg PFS			
☐ Reclast®				
☐ Remicade®				
☐ Synvisc®				
☐ Supartz®	☐ 25mg			
☐ Xeljanz®	☐ 5mg	☐ Take 5mg TWICE a day		

☐ Other medication:

By signing below, the prescriber gives consent to both, the prescription(s) above, as well as to Greater Placer Pharmacy to act as the prescriber's agent to begin and 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.

Prescriber Signature: _____ **Date:** _____ ☐**Do not substitute**

Patient Support Programs:

By signing below, I authorize Greater Placer Pharmacy to help me enroll in any or all patient co-pay assistance programs, including all foundations and manufacturer assistance programs. I authorize any communications among my providers, the pharmacy and the manufacturers regarding my health conditions and medications prescriptions in order to help coordinate the delivery of products and services through the various co-pay assistance programs. I understand that I may refuse to sign this form without affecting my ability to obtain treatment from the pharmacy. However, my refusal will not allow me to be enrolled in any co-pay assistance programs. If agreed, this signed authorization form (or a copy of this form) will be utilized as the original signed application for any and all possible foundations that may participate in the co-pay assistance programs, and it may serve such purpose.

Patient Signature: _____ **Date:** _____