Publix Specialty Pharmacy #3213

RHEUMATOLOGY (FORM A)

1950 Sand Lake Road, Bldg 5
Orlando, FL 32809
Phone: 855-797-8254
Fax: 863-413-5723

Patient Information [Attach copy of front and back of prescription insurance card(s)]

Patient's First Name: ______________________________________ Patient's Last Name: ______________________________________

Date of Birth: _____/_____/________ ☐ Male ☐ Female Caregiver Name:______________________________________

Address: ____ City: __________________ State: ___________ Zip: ____________

Primary Phone Number: (_____) _____________________________ Alt. Phone Number: (_____) ____________________________________

Clinical Information [Attach copy of labs and clinical notes] ☐ Urgent Request Using Cover My Meds: ☐ No ☐ Yes

Diagnosis code: __________________ Diagnosis: ☐ Rheumatoid Arthritis ☐ Ankylosing Spondylitis ☐ Other: ________________

Treatment status: ☐ New to therapy ☐ Continuation of therapy, start date: ______/______/_______ Is the patient on samples? ☐ No ☐ Yes

Previously denied by insurance? ☐ No ☐ Yes, include copy of denial letter Height: ______ ☐ cm ☐ in

TB test result (within 6 months): ☐ N/A ☐ Negative ☐ Positive, Date of TB test: ______/_______/_______ Weight: ______ ☐ kg ☐ lb

Allergies: ☐ NKDA ☐ Other: ____

Prior therapy, treatment dates, and reason for discontinuation: ____

MEDICATION	DOSE/STRENGTH	DIRECTIONS	DISPENSE QTY/DAYS	REFILLS
☐ Actemra (tocilizumab) Pt wt: _______	☐ 162 mg/0.9 mL ACTPen ☐ 162 mg/0.9 mL prefilled syringe (PFS)	☐ <100kg: Inject 162 mg SC every other week ☐ ≥100kg: Inject 162 mg SC every week	☐ 28 days ☐ 84 days	_______
	☐ 20 mg/ml vial	Infuse _________mg (_____mg/kg) IV over at least 1 hour every 4 weeks	1 dose	_______
☐ Cimzia (certolizumab)	☐ Starter Kit: 6 x 200 mg/mL PFS ☐ 200 mg vial	Initial Dose: Inject 400 mg SC on days 1, 15, and 29	3 doses	0
	☐ 200 mg/mL PFS ☐ 200 mg vial	Maintenance Dose: ☐ Inject 400 mg SC every 4 weeks ☐ Inject 200 mg SC every other week	☐ 28 days ☐ 84 days	_______
☐ Cosentyx (secukinumab)	☐ 150 mg/mL Sensoready pen ☐ 150 mg/mL PFS	Initial Dose: ☐ Inject 150 mg SC every week for 5 weeks (on days 1, 8, 15, 22, and 29)	4 doses	0
		Maintenance Dose: ☐ Inject 150 mg SC every 4 weeks	☐ 28 days ☐ 84 days	_______

Prescriber Information

Ship to prescriber: ☐ Never ☐ Always ☐ First fill only Appointment date: ______/______/__________

Name: ____ DEA# ____________________ NPI # ____________________________

Supervising Physician: ☐ Not Applicable ☐ _________________________________ Supervising Physician NPI # ______________________

Address: ____ City: __________________ State: ___________ Zip: ____________

Office Phone Number: (_____) _________________ Fax Number: (_____) __________________ Office Contact: _____________________

I authorize Publix Pharmacy representatives to act on behalf of the prescriber to initiate and complete the insurance prior authorization process.

Prescriber's signature: (stamps not accepted)

____________________________ ☐ Substitution allowed Date

____________________________________ ☐ Dispense as written/ Do not substitute Date

For states requiring hand written expressions to prevent substitution, write here:

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Publix Specialty Pharmacy #3213

RHEUMATOLOGY (FORM B)

1950 Sand Lake Road, Bldg 5
Orlando, FL 32809
Phone: 855-797-8254
Fax: 863-413-5723

Patient Information [Attach copy of front and back of prescription insurance card(s)]

Patient's First Name: ______________________________________ Patient's Last Name: ____

Date of Birth: _____/_____/________ ☐ Male ☐ Female Caregiver Name:____

Address: ____ City: __________________ State: ___________ Zip: ____________

Primary Phone Number: (_____) _____________________________ Alt. Phone Number: (_____) ___________________________________

Clinical Information [Attach copy of labs and clinical notes] ☐ Urgent Request Using Cover My Meds: ☐ No ☐ Yes

Diagnosis code: __________________ Diagnosis: ☐ Rheumatoid Arthritis ☐ Ankylosing Spondylitis ☐ Other: ________________

Treatment status: ☐ New to therapy ☐ Continuation of therapy, start date: ______/______/_______ Is the patient on samples? ☐ No ☐ Yes

Previously denied by insurance? ☐ No ☐ Yes, include copy of denial letter Height: ______ ☐ cm ☐ in

TB test result (within 6 months):☐ N/A ☐ Negative ☐ Positive, Date of TB test: ______/_______/_______ Weight: ______ ☐ kg ☐ lb

Allergies: ☐ NKDA ☐ Other: ____

Prior therapy, treatment dates, and reason for discontinuation: ____

MEDICATION	DOSE/STRENGTH	DIRECTIONS	DISPENSE QTY/DAYS	REFILLS
☐ Enbrel (etanercept)	50 mg/mL Mini cartridge 50 mg/mL SureClick pen 50 mg/mL PFS	Inject 50 mg SC every week	☐ 28 days ☐ 84 days	_______
☐ Humira (adalimumab)	☐ 40 mg/0.4mL pen (citrate-free) ☐ 40 mg/0.8mL pen ☐ 40 mg/0.4mL PFS (citrate-free) ☐ 40 mg/0.8mL PFS	☐ Inject 40 mg SC every other week ☐ Inject 40 mg SC every week	☐ 28 days ☐ 84 days	_______
☐ Kevzara (sarilumab)	☐ 200 mg/1.14 mL pen ☐ 150 mg/1.14 mL pen ☐ 200 mg/1.14 mL PFS ☐ 150 mg/1.14 mL PFS	Inject 1 dose SC every other week	☐ 28 days ☐ 84 days	_______
☐ Olumiant (baricitinib)	☐ 2 mg tablet ☐ 1 mg tablet	Take 1 tab PO one time daily	☐ 30 days ☐ 90 days	_______

Prescriber Information

Ship to prescriber: ☐ Never ☐ Always ☐ First fill only Appointment date: ______/______/__________

Name: ____ DEA# ____________________ NPI # ___________________________

Supervising Physician: ☐ Not Applicable ☐ _________________________________ Supervising Physician NPI # ______________________

Address: ____ City: __________________ State: ___________ Zip: ____________

Office Phone Number: (_____) ________________ Fax Number: (_____) __________________ Office Contact: _____________________

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Prescriber's signature: (stamps not accepted)

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RHEUMATOLOGY (FORM C)

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Patient Information [Attach copy of front and back of prescription insurance card(s)]

Patient's First Name: ______________________________________ Patient's Last Name: ____

Date of Birth: _____/_____/________ ☐ Male ☐ Female Caregiver Name:____

Address: ____ City: __________________ State: ___________ Zip: _____________

Primary Phone Number: (_____) ____________________________ Alt. Phone Number: (_____) ___________________________________

Clinical Information [Attach copy of labs and clinical notes] ☐ Urgent Request Using Cover My Meds: ☐ No ☐ Yes

Diagnosis code: __________________ Diagnosis: ☐ Rheumatoid Arthritis ☐ Ankylosing Spondylitis ☐ Other: ________________

Treatment status: ☐ New to therapy ☐ Continuation of therapy, start date: ______/______/_______ Is the patient on samples? ☐ No ☐ Yes

Previously denied by insurance? ☐ No ☐ Yes, include copy of denial letter Height: ______ ☐ cm ☐ in

TB test result (within 6 months):☐ N/A ☐ Negative ☐ Positive, Date of TB test: ______/_______/_______ Weight: ______ ☐ kg ☐ lb

Allergies: ☐ NKDA ☐ Other: ____

Prior therapy, treatment dates, and reason for discontinuation: ____

MEDICATION	DOSE/STRENGTH	DIRECTIONS	DISPENSE QTY/DAYS	REFILLS
☐ Orencia (abatacept)	☐ <60kg: 500 mg (2 vials) ☐ 60-100kg: 750 mg (3 vials) ☐ >100kg: 1000 mg (4 vials)	☐ Infuse one dose IV over 30 min, then within 24 hours start SC dosing	1 dose	0
		☐ Infuse one dose IV over 30 min on days 1, 15, and 29 then once every 4 weeks	1 dose	_______
Pt wt: _______	☐ 125 mg/mL ClickJect pen ☐ 125 mg/mL PFS	Inject 125 mg SC every week	☐ 28 days ☐ 84 days	_______
☐ Remicade (infliximab) ☐ Avsola (infliximab-axxq) ☐ Inflectra (infliximab-dyyb) ☐ Renflexis (infliximab-abda)	100 mg vial	Initial Dose: ☐ Infuse _________mg (_____mg/kg) IV over at least 2 hours on days 1, 15, and 43	2 doses	0
		Maintenance Dose: ☐ Infuse _________mg (_____mg/kg) IV over at least 2 hours every _____ weeks	1 dose	_______
Pt wt: _______	☐ SWFI 10ml vials	Use to reconstitute infliximab before dilution	QS	PRN
☐ Rinvoq (upadacitinib)	15 mg tablet	Take 1 tab PO one time daily	☐ 30 days ☐ 90 days	_______

Prescriber Information

Ship to prescriber: ☐ Never ☐ Always ☐ First fill only Appointment date: ______/______/__________

Name: ____ DEA# ____________________ NPI # ____________________________

Supervising Physician: ☐ Not Applicable ☐ _________________________________ Supervising Physician NPI # ______________________

Address: ____ City: __________________ State: ___________ Zip: _____________

Office Phone Number: (_____) ________________ Fax Number: (_____) __________________ Office Contact: _____________________

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Prescriber's signature: (stamps not accepted) ____________________________ ☐ Substitution allowed Date ____________________________________ ☐ Dispense as written/ Do not substitute Date

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RHEUMATOLOGY (FORM D)

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Patient Information [Attach copy of front and back of prescription insurance card(s)]

Patient's First Name: ______________________________________ Patient's Last Name: ____

Date of Birth: _____/_____/________ ☐ Male ☐ Female Caregiver Name:____

Address: ____ City: __________________ State: ___________ Zip: _____________

Primary Phone Number: (_____) ____________________________ Alt. Phone Number: (_____) ___________________________________

Clinical Information [Attach copy of labs and clinical notes] ☐ Urgent Request Using Cover My Meds: ☐ No ☐ Yes

Diagnosis code: __________________ Diagnosis: ☐ Rheumatoid Arthritis ☐ Ankylosing Spondylitis ☐ Other: ________________

Treatment status: ☐ New to therapy ☐ Continuation of therapy, start date: ______/______/_______ Is the patient on samples? ☐ No ☐ Yes

Previously denied by insurance? ☐ No ☐ Yes, include copy of denial letter Height: ______ ☐ cm ☐ in

TB test result (within 6 months): ☐ N/A ☐ Negative ☐ Positive, Date of TB test: ______/_______/_______ Weight: ______ ☐ kg ☐ lb

Allergies: ☐ NKDA ☐ Other: ____

Prior therapy, treatment dates, and reason for discontinuation: ____

MEDICATION	DOSE/STRENGTH	DIRECTIONS	DISPENSE QTY/DAYS	REFILLS
☐ Simponi (golimumab)	☐ 50 mg/0.5 mL SmartJect pen ☐ 50 mg/0.5 mL PFS	Inject 50 mg SC every 4 weeks	☐ 28 days ☐ 84 days	_______
☐ Simponi Aria (golimumab) Pt wt: _______	50 mg/4 mL vial	Initial Dose: ☐ Infuse __________ mg (2mg/kg) IV over 30 min on days 1 and 29	1 dose	0
		Maintenance Dose: ☐ Infuse __________ mg (2mg/kg) IV over 30 min every 8 weeks	1 dose	_______
☐ Taltz (ixekizumab)	☐ 80 mg/mL Pen ☐ 80 mg/mL PFS	Initial Dose: ☐ Inject 160 mg SC once on day 1	1 dose	0
		Maintenance Dose: ☐ Inject 80 mg SC every 4 weeks starting on day 29	☐ 28 days ☐ 84 days	_______
☐ Xeljanz (tofacitinib)	☐ 5 mg tablet	Take 1 tab PO twice a day	☐ 30 days ☐ 90 days	_______
	☐ 11 mg XR tablet	Take 1 tab PO one time daily		
☐ __________	___________________________________	____	_________	_______

Prescriber Information

Ship to prescriber: ☐ Never ☐ Always ☐ First fill only Appointment date: ______/______/__________

Name: ____ DEA# ____________________ NPI # ___________________________

Supervising Physician: ☐ Not Applicable ☐ _________________________________ Supervising Physician NPI # ______________________

Address: ____ City: __________________ State: ___________ Zip: _____________

Office Phone Number: (_____) ________________ Fax Number: (_____) __________________ Office Contact: _____________________

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Prescriber's signature: (stamps not accepted)

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