



SPECIALTY PHARMACY

RHEUMATOLOGY

New Orleans, LA toll free 888.355.4191 toll free fax 888.355.4192

krogerspecialtypharmacy.com

DATE: _____ NEEDS BY DATE: _____ SHIP TO: ☐ PATIENT ☐ OFFICE ☐ OTHER _____

PATIENT INFO		PRESCRIBER INFO	
Patient Name		Prescriber Name	
Address		DEA #	NPI # License #
City, State, Zip		Address	
Main Phone	Alternate Phone	City, State, Zip	
Social Security #		Phone	Fax
Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female	Contact Person	

PLEASE FAX COPY OF: ☐ PRESCRIPTION CARD FRONT & BACK ☐ CLINICAL NOTES ☐ MEDICAL CARD FRONT & BACK

CLINICAL INFORMATION

Diagnosis: ☐ M06.9 Rheumatoid Arthritis ☐ L40.50 Psoriatic Arthritis ☐ M45.9 Ankylosing Spondylitis ☐ M32.10 Systemic Lupus Erythematosus
☐ H20.9 Uveitis ☐ Other: _____ DX Code: _____

Drug Allergies: _____

Prior Failed Meds: ☐ Methotrexate Length of Treatment _____ ☐ Reason for Discontinuing _____
☐ _____ Length of Treatment _____ ☐ Reason for Discontinuing _____
☐ _____ Length of Treatment _____ ☐ Reason for Discontinuing _____

Does patient have a latex allergy? ☐ Yes ☐ No TB/PPD Test given (or intended to be given before biologic started)? ☐ Yes ☐ No (PLEASE send LAB result)

PRESCRIPTION INFORMATION			QUANTITY	REFILLS
<input type="checkbox"/> Actemra*	<input type="checkbox"/> 162mg Prefilled Syringe <input type="checkbox"/> _____ Vial	Inject 162mg subcutaneously <input type="checkbox"/> ONCE a week or <input type="checkbox"/> every OTHER week Infuse _____mg at _____	4 week supply	_____
<input type="checkbox"/> Benlysta*	<input type="checkbox"/> 120mg Vial <input type="checkbox"/> 400mg Vial 200mg <input type="checkbox"/> Autoinjector <input type="checkbox"/> PFS	<input type="checkbox"/> Load: Infuse _____mg at weeks 0, 2, and 4, then every 4 weeks thereafter <input type="checkbox"/> Maintenance: Infuse _____mg every 4 weeks Inject 200mg subcutaneously ONCE a week	4 week supply	_____
<input type="checkbox"/> Cimzia*	<input type="checkbox"/> 200x2 Prefilled Syringe <input type="checkbox"/> 200x2 LYO Powder	<input type="checkbox"/> Starter Kit: Inject 400mg subcutaneously at weeks 0, 2 and 4 <input type="checkbox"/> Maintenance: Inject 400mg SubQ once every 4 weeks or <input type="checkbox"/> Inject 200mg SubQ once every 2 weeks	1 Kit 4 week supply	none _____
<input type="checkbox"/> Cosentyx*	300mg (2x150) <input type="checkbox"/> Pen <input type="checkbox"/> PFS 150mg <input type="checkbox"/> Pen <input type="checkbox"/> PFS	<input type="checkbox"/> Load: Inject <input type="checkbox"/> 300mg or <input type="checkbox"/> 150mg subcutaneously week 0, 1, 2, 3, 4 <input type="checkbox"/> Maintenance: Inject <input type="checkbox"/> 300mg or <input type="checkbox"/> 150mg subcutaneously every 4 weeks	5 week supply 4 week supply	none _____
<input type="checkbox"/> Enbrel*	50mg <input type="checkbox"/> Sureclick <input type="checkbox"/> PFS 25mg <input type="checkbox"/> Vial <input type="checkbox"/> PFS	Inject 50mg subcutaneously ONCE a week Inject 25mg subcutaneously TWICE a week 72-96 hours apart	4 week supply	_____
<input type="checkbox"/> Humira*	<input type="checkbox"/> Uveitis Starter Kit <input type="checkbox"/> 40mg Pen <input type="checkbox"/> 40mg Prefilled Syringe	Inject 2-40mg (80mg) on day 1, then 40mg on day 8, then 40mg every other week <input type="checkbox"/> Inject 40mg subcutaneously every OTHER week <input type="checkbox"/> Inject 40mg subcutaneously ONCE a week	Loading Dose 4 week supply	none _____
<input type="checkbox"/> Kevzara*	<input type="checkbox"/> 200mg Prefilled Syringe <input type="checkbox"/> 150mg Prefilled Syringe	Inject 200mg subcutaneously once every 2 weeks Inject 150mg subcutaneously once every 2 weeks	4 week supply	_____
<input type="checkbox"/> Orencia*	125mg <input type="checkbox"/> ClickJect™ <input type="checkbox"/> PFS <input type="checkbox"/> 250mg Vial	Inject 125mg subcutaneously ONCE a week Infuse _____mg at _____	4 week supply	_____
<input type="checkbox"/> Otezla*	<input type="checkbox"/> Starter Pack <input type="checkbox"/> 30mg Tablets	<input type="checkbox"/> Titrate: Take 1 tablet on day 1 then twice daily as directed OR date provided _____ <input type="checkbox"/> Maintenance: Take 1 tablet by mouth twice daily. <input type="checkbox"/> Bridge Rx: Take 1 tablet by mouth twice daily; dispensed by OSP	1 Starter Pack 60 28	none _____ 12
<input type="checkbox"/> Remicade*	100mg Vial	Infuse _____mg at _____ wt _____	4 week supply	_____
<input type="checkbox"/> Rituxan*	_____	Infuse _____mg at _____	4 week supply	_____
<input type="checkbox"/> Simponi*	50mg <input type="checkbox"/> SmartJect <input type="checkbox"/> PFS <input type="checkbox"/> Aria	Inject 50mg subcutaneously ONCE a MONTH Infuse _____mg at weeks 0 and 4, then every 8 weeks thereafter	4 week supply	_____
<input type="checkbox"/> Stelara*	45mg Prefilled Syringe	<input type="checkbox"/> Inject 45mg on day 0, then week 4, then every 12 weeks <input type="checkbox"/> Inject 45mg every 12 weeks	1 1	_____ _____
<input type="checkbox"/> Xeljanz*	<input type="checkbox"/> 5mg Tablets <input type="checkbox"/> 11mg XR Tablets	Take 1 tablet by mouth twice daily Take 1 tablet by mouth once daily	60 30	_____ _____
<input type="checkbox"/> Other				

By signing this form and utilizing our services, you are authorizing Kroger Specialty Pharmacy™ and it's employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature (no stamps)

Substitution Permitted

Date

Prescriber's Signature (no stamps)

Dispense As Written

Date

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