PHONE: 1-855-419-4663
FAX: 1-417-269-0692

CoxHealth at Home

Rheumatology (A-E)

(Cimzia®, Cosentyx®, Enbrel®)

Patient Information

Patient name: _____ DOB: _____
Sex: ❑ Female ❑ Male SSN: _____
Language: _____ Wt: _____ ❑kg ❑lbs Ht: _____ ❑cm ❑in
Address: _____
Apt/Suite: _____ City: _____ State: _____ Zip: _____
Phone: _____ Alternate: _____
Caregiver name: _____ Relation: _____
Local pharmacy: _____ ___ Phone: _____
Insurance plan: _____ Plan ID: _____
Please fax a copy of front and back of the insurance card(s).

Prescriber + Shipping Information

Prescriber name: _____
NPI: _____
Address: _____
Apt/Suite: _____ City: _____ State: _____ Zip: _____
Contact: _____
Phone: _____ Alternate: _____
Fax: _____
Email: _____
If shipping to prescriber: ❑ First Fill ❑ Always ❑Never

Clinical Information (Please fax all pertinent clinical and lab information)

Diagnosis: ❑ M06.9 (Rheumatoid Arthritis) ❑ M08.0 (Juvenille Idiopathic Arthritis) ❑ L40.59 (Psoriatic Arthritis)
❑ M45.9 (Ankylosing Spondylitis) ❑ _____
Diagnosis Date: _____ _____ TB test: Yes No Negative Test Date: _____ _____ ___

Prior Therapy	Yes	No	Reason for Discontinuation of Therapy	Approximate Start Date	Approximate End Date
_____		___	_____	_____ __	_____ __
_____		___	_____	_____ __	_____ __
_____		___	_____	_____ __	_____ __

Comorbidities: _____ _____
Concomitant Medications: _____ _____ _____ _____
Allergies: NKDA Other: _____ _____ _____

Prescription		Quantity		Refill
❑ **Cimzia® (certolizumab)**	❑ Inject 400 mg SQ at weeks 0,2 and 4	6 x 200 mg/mL	❑ PFS ❑ Vials	0
	❑ Inject 200 mg SQ every 2 weeks ❑ Inject 400 mg SQ every 4 weeks	2 x 200 mg/mL	❑ PFS ❑ Vials	_____
❑ **Cosentyx® (secukinumab)**	❑ Inject 150 mg SQ once weekly at weeks 0, 1, 2 and 3	4 x 150 mg/mL	❑ Sensoready® Pen ❑ PFS	0
	❑ Inject 300 mg SQ once weekly at weeks 0, 1, 2 and 3	8 X 150 mg/mL		
	❑ Inject 150 mg SQ once weekly at week 4 and every 4 weeks thereafter	1 x 150 mg/mL	❑ Sensoready® Pen ❑ PFS	_____
	❑ Inject 300 mg SQ once weekly at week 4 and every 4 weeks thereafter	2 x 150 mg/mL		
❑ **Enbrel® (etanercept)**	❑ Inject 50 mg SQ every week	4 x 50 mg/mL	❑ SureClick® Autoinjector ❑ PFS ❑ Vials	_____
	❑ Inject _____ mg (0.8 mg/kg x _____ kg) SQ every week	____ x 25 mg/mL		

§ Actemra® is located on seperate form§

§ Humira®, Kevzara®, Orencia®, Otezla® are available on the Rheumatology Enrollment Form F-R §

§ Simponi®, Simponi Aria®, Stelara®, Taltz®, Xeljanz®, Xeljanz® XR are available on the Rheumatology Enrollment Form S-Z §

Injection Training Provided by: ❑ Prescriber 's Office ❑ Other: _____
❑ CoxHealth at Home, skilled nursing visits to teach self administrationof SQ injection and PRN if needed

Prescriber's Signature: _____ Date: _____

I authorize CoxHealth at Home and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time by providing written notice to CoxHealth at Home