CoxHealth at Home

Rheumatology® (R-Z)

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

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 phar macy: _____ ____ __ __ 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)
❑ L40.54 (Psoriatic Juvenille 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 Medi cations: _____ _____ _____ _____
Allergies: NKDA Other: _____ _____ _____

Prescription		Quantity		Refill
❑ **Rinvoq (upadacitinib)**	Take 15mg by mouth once daily	30 x 15mg tablets		_____
❑ **Simponi® (golimumab)**	Inject 50 mg SQ once a month	1 x 50 mg/0.5mL	❑ SmartJect® Autoinjector ❑ PFS	_____
❑ **Simponi Aria® (golimumab)**	❑ Infuse _____ mg (2 mg/kg x _____ kg) IV over 30 minutes at weeks 0	_____ x 50 mg/4ml	Vials	0
	❑ Infuse _____ mg (2 mg/kg x _____ kg) IV over 30 minutes at week 4 and every 8 weeks thereafter	_____ x 50 mg/4ml	Vials	_____
❑ **Stelara® (ustekinumab)**	❑ Inject 45 mg SQ on Day 1 (≤100 kg) ❑ Inject 90 mg SQ on Day 1 (>100 kg)	❑ 1 x 45 mg/0.5mL ❑ 1 x 90 mg/ mL	PFS	0
	❑ Inject 45 mg SQ on Day 29 and every 12 weeks thereafter (≤100 kg) ❑ Inject 90 mg SQ on Day 29 and every 12 weeks thereafter (>100 kg)	❑ 1 x 45 mg/0.5mL ❑ 1 x 90 mg/ mL	PFS	_____
❑ **Taltz® (Ixekizumab)**	❑ Inject 160 mg (2 x 80 mg) SQ on week 0	2 x 80 mg/mL	❑ Autoinjectors ❑ PFS	0
	❑ Inject 80 mg SQ on week 4 and 4 weeks thereafter	1 x 80 mg/mL	❑ Autoinjector ❑ PFS	_____
❑ **Xeljanz® (tofacitinib)**	❑ Take 5 mg by mouth twice daily ❑ _____	60 x 5 mg tablets _____		_____
❑ **Xeljanz® XR (tofacitinib)**	Take 11 mg by mouth once daily	30 x 11 mg tablets		_____

** Refer to Forms Rheumatology A-E and Rheumatology F-Q for applicable medications **

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

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

12-18-2020 Revised Date