RARE SPECIALTY PHARMACY
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P: (855) 713-7049 | F: (888) 509-1154
398 W Grand Ave | Rahway, NJ 07065

Today's Date: _____
Date Needed: _____

Patient Name: _____ Date of Birth: ____/____/____ Gender: _____ Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
Allergies/Notes: _____

(PLEASE ATTACH CLINICAL NOTES/LABS AND COPIES OF PATIENT'S INSURANCE CARDS)

Primary Insurance: _____ ID#: _____ Group#: _____ Insured's Name: _____
Employer: _____ City: _____ State: _____ Phone: _____

ICD-10 Diagnosis Code: ❑ L40.59 Psoriatic Arthritis ❑ M32.10 SLE ❑ M06.9 Rheumatoid Arthritis ❑ M45.9 Ankylosing Spondylitis ❑ M35.2 - Behcet's Disease
❑ M19.90 Osteoarthritis, unspecific site ❑ M81.0 Age-related osteoporosis w/o current fracture ❑ Other: _____
Previously treated for this condition? ❑ Yes ❑ No Medication(s) failed: _____
Patient currently taking Methotrexate? ❑ Yes ❑ No For Humira/Enbrel: PPD (TB Test) Results:_____ Date:_____ Total Swollen Joints:_____
Rheumatoid Factor Positive: _____ For Forteo: T-Score_____ Date: _____ Fracture History: Site: _____ Date: _____

RHEUMATOLOGY ORDER FORM

❑**AMJEVITA** ❑40mg/0.8mL PFS ❑40mg/0.8mL PFP Sure Click Autoinjector
SIG: Inject 40mg SQ every OTHER week QTY: 2 Refills:_____
❑If applicable, enroll patient in *Amgen Support+*
❑**HUMIRA PEN** 40mg/0.8mL ❑**HUMIRA PFS** 40mg/0.8mL
❑**HUMIRA CITRATE-FREE PEN** 40mg/0.4mL
❑**HUMIRA CITRATE FREE PFS** 40mg/0.4mL
SIG: ❑Inject 40mg SQ every OTHER week ❑Inject 40mg SQ ONCE a week
QTY:_____ Refills:_____ ❑If applicable, enroll patient in *Humira Complete*
❑**ENBREL** ❑SureClick Autoinjector 50mg ❑PFS 25mg ❑PFS 50mg
❑Multiuse Vial 25mg *(injection supplies included)* ❑Enbrel Mini/Auto Touch 50mg
SIG: ❑50mg once weekly ❑25mg twice weekly
QTY: 4 week supply Refills:_____ ❑If applicable, enroll patient in *Amgen Support+*
❑**CIMZIA** ❑200mg/1ml PFS 2-ct Pack ❑PFS 6-ct Starter Kit ❑If applicable, enroll patient in *CIMplicity*
❑Initial: Inject 400mg SQ at weeks, 0, 2, and 4 QTY: 1 Kit Refills: 0
❑Maintenance: Inject 200mg SQ every other week QTY: 1 Pack Refills: _____
❑Maintenance: Inject 400mg SQ every four weeks QTY: 1 Pack Refills: _____
❑Other:_____ QTY: 1 Pack Refills: _____
❑**SIMPONI** ❑SmartJect PEN 50mg/0.5mL ❑PFS 50mg/0.5mL
❑Inject 50mg subcutaneously once per month QTY: 1 month supply Refills:_____
SIMPONI ARIA ❑50mg/4ml (12.5mg/mL) in a single use vial
❑Initial: Inject 2mg/kg IV at weeks 0 and 4, then every 8 weeks
Patient Weight (kg):_____
QTY: _____ # of vials Refills:_____ ❑If applicable, enroll patient in *SimponiOne*
❑**REMICADE** 100mg Vial Dose: ❑3mg/kg ❑_____mg/kg Patient Weight (kg):_____
❑IV on weeks 0, 2, & 6 (Induction) QTY:_____ # of Vials Refills: 0
❑IV every 8 weeks (Maintenance Dose) QTY:_____ # of Vials Refills:_____
❑IV every _____ weeks QTY:_____ # of Vials Refills:_____
❑If applicable, enroll patient in *Janssen CarePath*

❑**FORTEO** 600mcg/2.4mL Pen ❑If applicable, enroll patient in *FORTEO Connect*
❑Inject 20mcg subcutaneously daily as directed QTY: 1 Pen Refills:_____
❑BD - 31G x 5mm PEN NEEDLES *use as directed w/ Forteo Pen* QTY: 100 (1 box) Refills:_____
❑**PROLIA** ❑60mg PFS ❑If applicable, enroll patient in *ProliaPlus*
❑Inject 60mg subcutaneously every 6 months QTY: 1 PFS Refills:_____
❑**EVENITY** ❑105mg/1.17mL PFS (2-ct pack)
❑Inject 210mg under the skin once monthly QTY: ❑2 PFS (1 month) ❑6 PFS (3 months) Refills:_____

❑**RINVOQ** 15mg tablet SIG: Take 1 tablet by mouth once daily QTY: 30 Refills:_____
❑**OLUMIANT** 2mg tablet SIG: Take 1 tablet by mouth once daily QTY: 30 Refills:_____
❑**XELSOURCE (XELJANZ)** 5mg tablet SIG: Take 1 tablet by mouth twice daily QTY: 60 Refills:_____
❑**XELJANZ XR** 11mg tablet SIG: Take 1 tablet by mouth once daily QTY: 30 Refills:_____
If applicable, enroll patient in ❑*myAbbVie Assist (Rinvoq)* ❑*Lilly Cares (Olumiant)* ❑*XELSOURCE (Xeljanz)*

❑**OTEZLA** Prescriber provided 2-Week Starter Pack on _____
Starter Dose: ❑28 Day Starter Pack SIG: Take as directed QTY: 55 Refills: 0
Maintenance Dose: ❑SIG: Take one tablet by mouth twice daily QTY: 60 Refills:_____
❑SIG: Take one tablet by mouth daily QTY: 30 Refills:_____
❑30mg twice daily (recommended) ❑30mg daily (for severe renal impairment)
❑If applicable, enroll patient in *Otezla SupportPlus* ❑If applicable, enroll patient in *Bridge RX Program*

❑**COSENTYX** ❑150mg Sensorady Pen ❑150mg PFS ❑If applicable, enroll patient in *Cosentyx Connect*
❑**Starter Dose:** Weeks 0, 1, 2, 3, and 4, then once every 4 weeks
SIG: ❑Inject 150mg dose SQ once weekly for 5 weeks QTY: 5 injection devices Refills: 0
SIG: ❑Inject 300mg dose SQ once weekly for 5 weeks QTY: 10 injection devices Refills: 0
Each 300mg dose is given as 2 SQ injections of 150 mg.
❑**Maintenance Dose:** Once every 4 weeks
SIG: ❑Inject 150mg dose SQ once every 4 weeks QTY:_____ Refills:_____
SIG: ❑Inject 300mg dose SQ once every 4 weeks QTY:_____ Refills:_____
Each 300mg dose is given as 2 SQ injections of 150 mg.

❑**TREMFYA** ❑PFS 100mg/mL ❑One-Press Injector 100mg/mL
❑Starter: Inject 100mg SQ on weeks 0 and 4, and every 8 weeks thereafter QTY:_____ Refills:_____
❑If applicable, enroll patient in *TREMFYA withMe*

OTHER:_____ SIG:_____ QTY:_____ Refills:_____

❑**BENLYSTA** ❑120mg Vial ❑400mg Vial Patient Weight (kg):_____
❑Initial Dose: Inject 10mg/kg IV every 2 weeks for first 3 doses
❑Maintenance Dose: Inject 10mg/kg IV every 4 weeks
QTY:_____ # of vials Refills:_____ ❑If applicable, enroll patient in *BENLYSTA Connects*

❑**KRYSTEXXA** ❑8mg/mL SDV QTY:_____ vials Refills:_____
SIG: 8mg every 2-weeks give as an IV infusion

❑**ZILRETTA** ❑32mg kit QTY:_____ kits Refills:_____
SIG: 32mg administered as a single intra-articular injection in the knee

❑**RAYOS** ❑1mg ❑2mg ❑5mg SIG:_____ QTY:_____ Refills:_____
❑**PENNSAID 2% SOLUTION** 112g pump bottle
SIG: Apply 2 pumps to the affected joint twice daily QTY:_____ Refills:_____

❑**KEVZARA** ❑200mg/1.14mL ❑150mg/1.14mL ❑Pre-filled Pens ❑Pre-filled Syringes
Dispense: ❑Inject 150mg subcutaneously every other week QTY: 2 Refills:_____
❑Inject 200mg subcutaneously every other week QTY: 2 Refills:_____
ANC:_____ Platelets:_____ Liver Function Tests:_____
❑If applicable, enroll patient in *KevzaraConnect*
❑**ACTEMRA** ❑ACTPen 162mg/0.9mL ❑PFS 162mg/0.9mL ❑Vial 400mg/20mL
Dosing: ❑<100kg: Inject 162mg SQ once every other week QTY:_____ Refills:_____
❑≥100kg: Inject 162mg SQ once every week QTY:_____ Refills:_____
❑IV: Infuse 4mg/kg IV once every 4 weeks QTY:_____ Refills:_____
❑Other:_____ QTY:_____ Refills:_____
❑If applicable, enroll patient in *Actemra Access Solutions*

❑**METHOTREXATE TABS** ❑**RASUVO** ❑**OTREXUP** ❑If applicable, enroll patient in *CORE Connections*
❑SQ: Inject _____mg SQ once weekly QTY:_____ Refills:_____
❑Oral: Take _____mg by mouth once weekly QTY:_____ Refills:_____
❑Other:_____ QTY:_____ Refills:_____

❑**KINERET** 100mg/0.67mL PFS ❑If applicable, enroll patient in *KINERET On TRACK*
❑Inject 100mg (0.67mL) SQ QD QTY: 1 PFS Refills:_____
❑**ORENCIA** *Carton of 4 autoinjectors:* ❑125mg PFS ❑250mg Vial ❑125mg ClickJect
❑Inject 125mg SQ weekly ❑Other: _____
❑<60kg Infuse 500mg at weeks 0, 2, and 4, then every 4 weeks thereafter _____
❑60-100kg Infuse 750mg at weeks 0, 2, and 4, then every 4 weeks thereafter _____
❑>100kg Infuse 1000mg at weeks 0, 2, and 4, then every 4 weeks thereafter
QTY: 4 week supply Refills:_____ ❑If applicable, enroll patient in *ORENCIA On Call*
❑**RITUXAN** ❑100mg/10mL Vial ❑500mg/50mL Vial QTY:_____ vials Refills:_____
❑Infuse 1000mg on day 1 and day 15, repeat course every 24 weeks
❑Other:_____
❑**TRUXIMA** ❑100mg/10mL SDV ❑500mg/50mL Vial SDV QTY:_____ vials Refills:_____
SIG: Infuse 1000mg on day 1 and day 15, repeat course every 24 weeks

❑**STELARA** ❑45mg/0.5mL PFS (for patients weighting <100kg (220lbs) Patient Weight (kg):_____
❑**Starter Dose:** Inject 45mg (1 PFS) SQ initially QTY: 1 PFS Refills: 0
Inject 45mg (1 PFS) SQ 4 weeks later QTY: 1 PFS Refills: 0
❑**Maintenance Dose:** Inject 45mg (1 PFS) SQ every 12 weeks QTY: 1 PFS Refills: _____
❑90mg/mL PFS (for patients weighting >100kg (220lbs)
❑**Starter Dose:** Inject 90mg (1 PFS) SQ initially QTY: 1 PFS Refills: 0
Inject 90mg (1 PFS) SQ 4 weeks later QTY: 1 PFS Refills: 0
❑If applicable, enroll patient in *Janssen CarePath*

❑**TALTZ 80mg** ❑Autoinjector ❑Prefilled Syringe
❑**Starter Dose:** Inject 160mg SQ at week 0 QTY:_____ Refills: 0
❑**Maintenance Dose:** Inject 80mg SQ at week 4 and every 4 weeks thereafter QTY:_____ Refills:_____
❑If applicable, enroll patient in *Taltz Together*

❑**SKYRIZI** 150mg/mL ❑PFS ❑PEN *PSORIATIC ARTHRITIS*
❑**Starter Dose:** Inject 150mg SQ at week 0 and week 4 QTY: 2 Refills:_____
❑**Maintenance Dose:** Inject 150mg SQ every 12 weeks thereafter QTY:_____ Refills:_____
❑If applicable, enroll patient in *Skyrizi Complete*

This prescription will be filled generically unless the prescriber writes "DAW" here: _____

Prescriber Name/Practice:_____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____ Office Contact: _____
License#: _____ NPI#: _____ UPIN#: _____ DEA#: _____
Prescriber's Signature (signature required, no stamps): _____ Date: _____