Patient Information	Acc	ess	Rheumatology Pres	cription Refe	erral Form (A	<b>\-E)</b>	
Fax: 661-489-3553   Please contact us at 661-489-3500 or toll fire [8]	Specialty I	Pharmacy					
Deliver to:	nd your RX to:		Fax: 661-489-3553		· ·		
Patient Name:  Soci See 6:  Preferred Phone:  City:  City: Ci							Injection trainin
incose Ref. Preferred Phone:   Snown Allergies:   State:   Zip:							
City:   State:   Zip:	Patient Name:		Birthdate:			Weight:	_ Ibs. Kg.
Insurance Information: Please Fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)  2. Prescriber Information    Provider Name:			one:	City:	State:		
Prescriber Information   DEA R:   Proper   Face   Proper   Prope						2.p	
DEA F:   NPIE:	nsurance Info	ormation: Please Fax FRONT and BAC	Copy of ALL Insurance cards (	Prescription and Med	lical)		
DEA F:   NPIE:	2. Prescribe	r Information					
Stage   2Ps   Stage			DEA #:		NPI#:		
Diagnosis/Clinical Information   Please FAX recent clinical notes, labs, Tests, with the prescription   Illignosis - Please include diagnosis many with ICD-10 code   Additional Information   Therapy:   Diew   Resulthorization   Restart   MoS 3 New   Resulthorization   Restart   Resulthorization   Restar							
Name	ity, State, ZIP: _		Key Contact:		Phone:		
Name	R· Diagnosis	Clinical Information Pleas	se FΔX recent clinical notes Tak	ns Tests with the nre	scrintion		
Mode of Reference   Mode arthritis, unspecified   Mode   Melight			te 1700 recent emiliar notes, las	•	•	□ Reauthorization	□ Restart
MOB.00 Unspecified juvenile rheumatoid arthritis of unspecified site   MoB.3 Juvenile feumatoid polynthitis (seronegative)   MOB.3 Mobility (Seronegative)   MOB.3		3					cm =
M45 9 Ankylosing spondylitis of unspecified stee in spine			fied site	Allergies:			
Lido Sp Other Psoriatic Anthropathy   Concomitant Medications:   Additional Comments:   Injection Training Required:   Tyes   No   No   No   No   No   No   No   N							
Additional Comments:   Injection Training Required:   Ves   No   No   No   No   No   No   No   N		•					
Injection Training Required:	□ L40.59 Other Psoriatic Anthropathy						
See See See   Performed?   Yes   No   No   No   No   No   No   No   N							
Does the patient have an active infection?   Yes   No   No	las a TB test bee	en performed?	injection realing requ				
### Prescription Information    Medication   Dose/Strength   Sig   Qt							
Dose/Strength	Start Date	Review Date					
Dose/Strength	4.5						
□ Actemra □ 162mg/0.9ml Prefilled Syringe □ 162mg/0.9ml Actemra □ 200mg/ml Prefilled Syringe □ 200mg/ml Prefilled Syringe □ 200mg/ml Autoinjector □ Maintenance Dose: Inject 200 mg SQ once every week □ 200mg/ml Autoinjector □ Induction Dose: Inject 400mg SQ at weeks 0, 2 and 4 □ 200mg/ml Starter Kit (6 prefilled Syringes □ 200mg/ml Vial Kit □ Induction Dose: Inject 400mg SQ at weeks 0, 2 and 4 □ 200mg/ml Vial Kit □ Maintenance Dose: Inject 200mg SQ every OTHER week □ 200mg/ml Vial Kit □ Maintenance Dose: Inject 400 mg SQ every ofter weeks □ 200mg/ml Vial Kit □ Maintenance Dose: Inject 400 mg SQ every ofter weeks □ 200mg/ml Vial Kit □ Maintenance Dose: Inject 400 mg SQ every ofter weeks □ 200mg/ml Vial Kit □			1	-			0: /2 (
Garag/O.9ml ACTPEN   Autoinjector   For patients weighing > 100 kg: Inject 162mg SQ every week   Qtv_Refilled   Quomg/ml Prefilled Syringe   Quomg/ml Autoinjector   Maintenance Dose: Inject 200 mg SQ once every week   Qtv_Refilled   Quomg/ml Starter Kit (6 prefilled Syringes)   Maintenance Dose: Inject 200 mg SQ at weeks 0, 2 and 4   Qtv_Refilled Syringes   Quomg/ml Vial Kit   Maintenance Dose: Inject 200 mg SQ every OTHER week   Qtv_Refilled Syringes   Quomg/ml Vial Kit   Maintenance Dose: Inject 400 mg SQ every OTHER week   Qtv_Refilled Syringe   Quomg/ml Vial Kit   Maintenance Dose: Inject 400 mg SQ every four weeks   Qtv_Refilled Syringe   Quomg/ml Vial Kit   Quomg/ml Vial Vial Kit   Quomg/ml Vial Kit   Quomg/m			_ For nationts weighing < 100		want ather wools falls	awad by an ingrassa	Qty/Refil
Autoinjector   For patients weighing > 100 kg: Inject 162mg SQ every week   Refill   Glovery   Programs: Please sign and date below to enroll in the pharmaceutical company assisted patient support program (if applicable)   Date:		, ,			every other week, follo	owed by an increase	to Qty:
Benlysta   200mg/ml Prefilled Syringe   200mg/ml Autoinjector   Maintenance Dose: Inject 200 mg SQ once every week   20ty_Refill   200mg/ml Autoinjector   Maintenance Dose: Inject 200mg SQ once every week   20ty_Refill   200mg/ml Starter Kit (6 prefilled syringes)   Inject 200mg SQ at weeks 0, 2 and 4   20ty_Refill   200mg/ml Vial Kit   Maintenance Dose: Inject 200mg SQ every OTHER week   20ty_Refill   200mg/ml Vial Kit   Maintenance Dose: Inject 400 mg SQ every four weeks   20ty_Refill   200mg/ml Vial Kit   Maintenance Dose: Inject 400 mg SQ every four weeks   20ty_Refill   200mg/ml SQ every four weeks   200mg/ml SQ every four we		0,		•	wan i waali		Refills:
200mg/ml Autoinjector		-					Qty:
Cimzia   200mg/ml Starter Kit (6 prefilled syringes)   Induction Dose: Inject 400mg SQ at weeks 0, 2 and 4   Otyr_Refilled syringes   Other:   Ot		, ,	iviaintenance bose. Inject 2	oo nig sq once every v	veek		αιγ
Syringes)    Refill   Cimzia   200mg/ml Vial Kit   Maintenance Dose: Inject 200mg SQ every OTHER week   Other:   Refill   Other:   Cosentyx   Sensoready pen 150 mg/ml   Injection   Prefilled Syringe 150mg/ml   Injection   Prefilled Syringe 150mg/ml   Injection   Diplect 300 mg (2 injections) SQ at weeks 0, 1, 2, 3, and 4 (0 refills)   Maintenance Dose: Inject 300 mg (2 injections) SQ every 4 weeks   Other Psoriatic Arthritis with Coexisting Moderate to Severe Plaque Psoriasis   Other:   Loading Dose: Inject 300 mg (2 injections) SQ at weeks 0, 1, 2, 3, and 4 (0 refills)   Maintenance Dose: Inject 300 mg (2 injections) SQ every 4 weeks   Other Psoriatic Arthritis or Ankylosing Spondylitis   With Loading Dose: Inject 150mg (1 injection) SQ at weeks 0, 1, 2, 3 and 4, and then every 4 weeks thereafter (0 refills)   Without Loading Dose: Inject 150 mg (one injection) SQ every 4 weeks   Other:   Other:   Inject 25 mg SQ twice a week (72 – 96 hours apart)   Inject 50mg/ml Enbrel Mini Prefilled Catridge for use with the AutoTouch reusable autoinjector only   Other:   Other:		200mg/mi Automjector					Refills:
Cimzia		☐ 200mg/ml Starter Kit (6 prefilled	☐ Induction Dose: Inject 400n	ng SQ at weeks 0, 2 and	d 4		Qty:
Cimzia   200mg/ml Vial Kit   Maintenance Dose: Inject 200mg SQ every OTHER week   Advisionance Dose: Inject 400 mg SQ every four weeks   Other:   Refill   Cosentyx   Sensoready pen 150 mg/ml   Injection   Psoriatic Arthritis with Coexisting Moderate to Severe Plaque Psoriasis   Other:   Dading Dose: Inject 300 mg (2 injections) SQ at weeks 0, 1, 2, 3, and 4 (0 refills)   Maintenance Dose: Inject 300 mg (2 injections) SQ every 4 weeks   Other Psoriatic Arthritis or Ankylosing Spondylitis   With Loading Dose: Inject 150mg (1 injection) SQ at weeks 0, 1, 2, 3 and 4, and then every 4 weeks thereafter (0 refills)   Without Loading Dose: Inject 150mg (1 injection) SQ every 4 weeks   Other:		syringes)					
Maintenance Dose: Inject 400 mg SQ every four weeks   Other:   Other:   Psoriatic Arthritis with Coexisting Moderate to Severe Plaque Psoriasis   Ottyr_   Cosentyx   Injection   Psoriatic Arthritis with Coexisting Moderate to Severe Plaque Psoriasis   Ottyr_   Coading Dose: Inject 300 mg (2 injections) SQ at weeks 0, 1, 2, 3, and 4 (0 refills)   Maintenance Dose: Inject 300 mg (2 injections) SQ every 4 weeks   Other Psoriatic Arthritis or Ankylosing Spondylitis   With Loading Dose: Inject 150mg (1 injection) SQ at weeks 0, 1, 2, 3 and 4, and then every 4 weeks thereafter (0 refills)   Without Loading Dose: Inject 150 mg (one injection) SQ every 4 weeks   Other:   Inject 25 mg SQ twice a week (72 – 96 hours apart)   Inject 50mg/ml Sureclick Autoinjector   Somg/ml Sureclick Autoinjector   Somg/ml Prefilled Syringe   Somg/ml Enbrel Mini Prefilled   Other:		- 200 / - LV - LV	- Mariaha a a a Baran Inirah 2	100 CO OTUED			
Cosentyx   Sensoready pen 150 mg/ml   Psoriatic Arthritis with Coexisting Moderate to Severe Plaque Psoriasis   Qty:_   Loading Dose: Inject 300 mg (2 injections) SQ at weeks 0, 1, 2, 3, and 4 (0 refills)   Maintenance Dose: Inject 300 mg (2 injections) SQ every 4 weeks   Qther Psoriatic Arthritis or Ankylosing Spondylitis   With Loading Dose: Inject 150mg (1 injection) SQ at weeks 0, 1, 2, 3 and 4, and then every 4 weeks thereafter (0 refills)   Without Loading Dose: Inject 150mg (1 injection) SQ every 4 weeks   Qther:_   Qty:_   Diject 25 mg SQ twice a week (72 – 96 hours apart)   Inject 50mg/ml Sureclick Autoinjector   Somg/ml Prefilled Syringe   Somg/ml Enbred Mini Prefilled Catridge for use with the AutoTouch reusable autoinjector only   Patient Support Programs: Please sign and date below to enroll in the pharmaceutical company assisted patient support program (if applicable)   Date:_   Date:_	□ Cimzia	□ 200mg/mi viai kit					Qty
Sensoready pen 150 mg/ml   Injection   Psoriatic Arthritis with Coexisting Moderate to Severe Plaque Psoriasis   Otty:   Loading Dose: Inject 300 mg (2 injections) SQ at weeks 0, 1, 2, 3, and 4 (0 refills)   Maintenance Dose: Inject 300 mg (2 injections) SQ every 4 weeks   Other Psoriatic Arthritis or Ankylosing Spondylitis   With Loading Dose: Inject 150mg (1 injection) SQ at weeks 0, 1, 2, 3 and 4, and then every 4 weeks thereafter (0 refills)   Without Loading Dose: Inject 150 mg (no injection) SQ every 4 weeks   Other:   Inject 25 mg SQ twice a week (72 – 96 hours apart)   Inject 50mg/ml Sureclick Autoinjector   S0mg/ml Prefilled Syringe   S0mg/ml Enbrel Mini Prefilled   Other:   Other:   Other:   Refill   Refill   Refill   Refill   Surport Programs: Please sign and date below to enroll in the pharmaceutical company assisted patient support program (if applicable)   Date:   Data			, , ,				
Injection	Casantuu	= Conserved was 150 mg/ml		ting Madarata to Cover	o Diagua Dagriagia		Otv:
Maintenance Dose: Inject 300 mg (2 injections) SQ every 4 weeks   Other Psoriatic Arthritis or Ankylosing Spondylitis   With Loading Dose: Inject 150mg (1 injection) SQ at weeks 0, 1, 2, 3 and 4, and then every 4 weeks thereafter (0 refills)   Without Loading Dose: Inject 150 mg (one injection) SQ every 4 weeks   Weeks thereafter (0 refills)   Without Loading Dose: Inject 150 mg (one injection) SQ every 4 weeks   Other:	□ Cosentyx	, ,				(O rofills)	αιγ
Other Psoriatic Arthritis or Ankylosing Spondylitis   With Loading Dose: Inject 150mg (1 injection) SQ at weeks 0, 1, 2, 3 and 4, and then every 4 weeks thereafter (0 refills)   Injection   Without Loading Dose: Inject 150 mg (one injection) SQ every 4 weeks   Other:		Injection				(O Terms)	Refills:
With Loading Dose: Inject 150mg (1 injection) SQ at weeks 0, 1, 2, 3 and 4, and then every 4 weeks thereafter (0 refills)   Without Loading Dose: Inject 150 mg (one injection) SQ every 4 weeks   Other:					Levely 4 weeks		
Prefilled Syringe 150mg/ml   weeks thereafter (0 refills)   Without Loading Dose: Inject 150 mg (one injection) SQ every 4 weeks   Other:					atweeks 0 1 2 3 and	1 4 and then every 4	
Injection		□ Prefilled Syringe 150mg/ml		Some (1 mjection) se (	at weeks 0, 1, 2, 5 and	i, and then every i	
Cother:		, 0 0,	,	ect 150 mg (one injection	on) SO every 4 weeks		
25mg Vial		,		(	,		
25mg Vial	□ Enbrel	□ 25mg/0.5ml Prefilled Syringes	□ Inject 25 mg SQ twice a wee	ek (72 – 96 hours apart	)		Qty:
50mg/ml Sureclick Autoinjector   Other:   Refills   Somg/ml Prefilled Syringe   50mg/ml Enbrel Mini Prefilled   Catridge for use with the AutoTouch   reusable autoinjector only   Patient Support Programs: Please sign and date below to enroll in the pharmaceutical company assisted patient support program (if applicable)   Patient Signature:   Date:   Date			☐ Inject 50mg SQ once a weel	k	•		
□ 50mg/ml Prefilled Syringe □ 50mg/ml Enbrel Mini Prefilled Catridge for use with the AutoTouch reusable autoinjector only  Patient Support Programs: Please sign and date below to enroll in the pharmaceutical company assisted patient support program (if applicable) atient Signature:  Date:		□ 50mg/ml Sureclick Autoinjector					Refills:
Catridge for use with the AutoTouch reusable autoinjector only  Patient Support Programs: Please sign and date below to enroll in the pharmaceutical company assisted patient support program (if applicable) atient Signature:  Date:		□ 50mg/ml Prefilled Syringe					
reusable autoinjector only  Patient Support Programs: Please sign and date below to enroll in the pharmaceutical company assisted patient support program (if applicable)  atient Signature:  Date:		□ 50mg/ml Enbrel Mini Prefilled					
reusable autoinjector only  Patient Support Programs: Please sign and date below to enroll in the pharmaceutical company assisted patient support program (if applicable)  atient Signature:  Date:		0.					
atient Signature: Date:		reusable autoinjector only					
atient Signature: Date:							
		Patient Support Programs: Please sign a	and date below to enroll in the p	harmaceutical compar	ny assisted patient sup	pport program (if app	olicable)
	ationt Cianatura	a.			Date		
Processing Authorization: Lauthorization is authorized this pharmacy and its convergentatives to act as my authorized agent to secure coverage and letters to be increased as a substitute to be increased for any action in the convergence of t	atient Signature				Date:		
rescriber Authorization, rauthorize this pharmacy and its representatives to act as fify authorized agent to secure coverage and militate the insurance prior authorization process for my patientis), and to sign any neces.	rescriber Authoriza	tion: I authorize this pharmacy and its representative	s to act as my authorized agent to secure of	coverage and initiate the insura	ance prior authorization prod	ess for my patient(s), and t	o sign any necessary forr

Prescriber's Signature: Date: I authorize Access Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process