

Patient Information				Prescriber Information	
Patient Name:		DOB:		Prescriber's Name:	
Address:				NPI#:	
City:	State:	Zip:	DEA#:		License#:
Phone:		Alternate Phone:		Address:	
Height:	Weight:	Allergies:		Phone:	Fax:
Emergency Contact:		Phone:		Contact Person:	
Is the patient pregnant, planning a pregnancy or nursing: Yes No				Does the patient need interpreter services: Yes No	

Documentation (Required)		
Insurance Card (ID & Group #)	Current Medications	History/Progress Notes

Labs Needed Prior to Initiation			
Tuberculosis	Hepatitis B antigen and antibody	CBC with diff	CMP

Diagnosis				
ICD-10 Codes:	M06.9 Rheumatoid Arthritis	L40.59 Psoriatic Arthritis	M45.9 Ankylosing Spondylitis	M10.9 Gout
M32 Systemic Lupus Erythematosus Other: _____				

Medication			Qty	Refills
ACTEMRA® PFS (tocilizumab) ACTEMRA ACTPEN® (tocilizumab)	162 mg/0.9 mL	Inject 162 mg subq Every week Every other week		
BENLYSTA® (belimumab) PFS Pen IV	200 mg/mL 120 mg vial 400 mg vial	Inject 200 mg/mL subq every week Initial: Infuse 10 mg/kg = _____ mg IV every 2 weeks x 3 doses Maintenance: Infuse 10 mg/kg = _____ mg IV every 4 weeks		
CIMZIA® (certolizumab pegol)	200 mg/mL	Initial: Inject 400 mg subq at weeks 0, 2, and 4 Maintenance: Inject 200 mg subq every other week Inject 400 mg subq every 4 weeks		
COSENTYX® (secukinumab) PFS Pen COSENTYX UNOREADY PEN® (secukinumab)	150 mg/mL 300 mg/2 mL	Initial: Inject 150 mg subq at weeks 0, 1, 2, 3, and 4 Maintenance: Inject 150 mg subq every 4 weeks Inject 300 mg subq every 4 weeks		
ENBREL® (etanercept) PFS Sureclick ENBREL MINI® (etanercept)	25 mg/mL 50 mg/mL	Inject 25 mg subq two times per week Inject 50 mg subq every week		

Medication			Qty	Refills
HUMIRA® (adalimumab) PFS Pen Other biosimilar: _____	40 mg/0.4 mL 40 mg/0.8 mL	Inject 40 mg subq every other week Inject 40 mg subq every week Inject 80 mg subq every other week		
METHOTREXATE	2.5 mg tablets 50 mg/2mL inj	Take ___ tablets bby mouth every week Inject ____ mg subq every week		
ORENCIA® PFS (abatacept) ORENCIA® Clickject (abatacept) ORENCIA® IV (abatacept)	125 mg/mL 250 mg vial	Inject 125 mg subq every week Initial: I < 60 kg: 500 mg I 60-100 kg: 750 mg I > 100 kg: 1000mg Infuse ____ mg IV at weeks 0, 2, and 4 Maintenance: Infuse ____ mg IV every 4 weeks		
OTEZLA® (apremilast)	Starter Pack 30 mg tablets	Take by mouth: 10 mg in the AM Day 2: 10 mg in the AM and PM Day 3: 10 mg in the AM, 20 mg in the PM Day 4: 20 mg in the AM and PM Day 5: 20 mg in the AM and 30 mg in the PM Day 6: 30 mg two times per day Maintenance: Take one tablet by mouth two times per day Other: _____	1 Pack (#55)	
RASUVO® (methotrexate)	7.5 mg/0.15 mL 10 mg/0.2 mL 12.5 mg/0.25 mL 15 mg/0.3 mL 17.5 mg/0.35 mL 20 mg/0.4 mL 22.5 mg/0.45 mL 25 mg/0.5 mL 30 mg/0.6 mL	Inject ____ mg subq every week		
REMICADE® (infliximab) Other biosimilar: _____	100 mg vial	Initial: Infuse 5 mg/kg = ____ mg IV at weeks 0, 2, and 6 Maintenance: 5 mg/kg = ____ mg IV every 8 weeks Other: _____		
RINVOQ® (upadacitinib)	15 mg tablet	Take one tablet by mouth every day		
SIMPONI® (golimumab) PFS Pen SIMPONI ARIA® (golimumab)	50 mg/0.5 mL 50 mg/4 mL vial	Inject 50 mg subq every month Initial: Infuse 2 mg/kg = ____ mg IV at weeks 0 and 4 Maintenance: Infuse 2 mg/kg = ____ mg IV every 8 weeks		

Medication			Qty	Refills
SKYRIZI® (risankizumab) PFS Pen	150 mg/mL	Initial: Inject 150 mg subq at weeks 0 and 4 Maintenance: Inject 150 mg subq every 12 weeks		
STELARA® (ustekinumab) PFS Pen Other biosimilar:	45 mg/0.5 mL (<= 100 kg) 90 mg/mL (> 100 kg)	Initial: Inject 45 mg subq at weeks 0 and 4 Maintenance: Inject 45 mg subq every 12 weeks OR Initial: Inject 90 mg subq at weeks 0 and 4 Maintenance: Inject 90 mg subq every 12 weeks		
TALTZ® (ixekizumab) PFS Pen	80 mg/mL	Initial: Inject 160 mg subq x 1 Maintenance: Inject 80 mg subq every 4 weeks		
TREMFYA® (guselkumab) PFS Pen	100 mg/mL	Initial: Inject 100 mg subq at weeks 0 and 4 Maintenance: Inject 100 mg subq every 8 weeks		
XELJANZ® (tofacitinib) XELJANZ XR® (tofacitinib)	5 mg tablet 11 mg tablet 22 mg tablet	Take one tablet by mouth two times per day Take one tablet by mouth every day		

By signing this form I authorize AleraCare and its representatives to act as my agent in order to initiate and execute the insurance prior authorization process and, in doing so release clinical information via phone to the appropriate third party payer.

Prescriber's Signature

Date