

Rheumatology Prescription Form

Please complete the prescription form in its entirety and fax with secure cover sheet to the number above.

Patient information

Patient: _____ Female Male DOB: _____ Height: _____ Weight: _____ lb kg Date: _____
 Address: _____ City: _____ State: _____ ZIP code: _____
 Home phone #: _____ Cell phone #: _____ Caregiver: _____ Caregiver phone #: _____
 Other medical conditions: _____ Allergies: No Yes: _____
 Insurance plan: _____ Plan ID #: _____ BIN: _____ PCN: _____ Group #: _____
 *Please send a copy of the patient’s prescription insurance card if available.

Clinical information

ICD-10 code: _____ Diagnosis: _____ Diagnosis date: _____
 Concurrent medications: _____
 Is the patient taking methotrexate? No Yes
 Prior medications: acetaminophen, ibuprofen or naproxen sodium Azulfidine Calcipotriene Celebrex corticosteroids
 Enbrel Humira Indocin Kevzara methotrexate
 Justification for prior medications: _____
 TB test: No Yes Date of negative TB test: _____
 HBV: No Yes If yes, currently treated? No Yes

Medication

<input type="checkbox"/> Abrilada	<input type="checkbox"/> Hulio	<input type="checkbox"/> Remicade	<input type="checkbox"/> Tremfya
<input type="checkbox"/> Actemra	<input type="checkbox"/> Humira	<input type="checkbox"/> Renflexis	<input type="checkbox"/> Tyenne
<input type="checkbox"/> Amjevita	<input type="checkbox"/> Hyrimoz	<input type="checkbox"/> Rinvoq	<input type="checkbox"/> Xeljanz
<input type="checkbox"/> Avsola	<input type="checkbox"/> Idacio	<input type="checkbox"/> Rinvoq LQ	<input type="checkbox"/> Xeljanz XR
<input type="checkbox"/> Cimzia	<input type="checkbox"/> Inflectra	<input type="checkbox"/> Simponi	<input type="checkbox"/> Yuflyma
<input type="checkbox"/> Cosentyx	<input type="checkbox"/> Kevzara	<input type="checkbox"/> Simponi Aria	<input type="checkbox"/> Yusimry
<input type="checkbox"/> Cyltezo	<input type="checkbox"/> Olumiant	<input type="checkbox"/> Skyrizi	<input type="checkbox"/> Zymfentra
<input type="checkbox"/> Enbrel	<input type="checkbox"/> Orencia	<input type="checkbox"/> Stelara	
<input type="checkbox"/> Hadlima	<input type="checkbox"/> Otezla	<input type="checkbox"/> Taltz	

Prescription information Note: Ohio law allows one prescription per preprinted order form. Please use additional forms for more than one prescription.

Dosage Form	Dose	Directions	Quantity	Refills
	Initial Dose			
	Maintenance Dose			
	Other			

Prescriber and shipping information (please print)

Prescriber: _____ NPI: _____
 Ship to: Patient Office Other: _____
 Office address: _____ City: _____ State: _____ ZIP code: _____
 Office phone number: _____ Office fax number: _____
 Signature: _____ Date: _____
 We will dispense this prescription as generic, unless the prescriber indicates “Dispense as Written” here: _____
 The prescriber is to comply with his/her state-specific prescription requirements, such as e-prescribing, state-specific prescription form and fax language. Noncompliance with state-specific requirements could result in outreach to the prescriber.