Spring Creek Pharmacy

RHEUMATOLOGY
Phone: 972-517-7900
Fax: 972-517-0400
280 Legacy Drive #102 Plano,TX 75023

DATE _____ NEEDS BY DATE: _____ SHIP TO: ❑ PATIENT ❑ OFFICE ❑ OTHER _____

PATIENT INFORMATION

Patient Name	
Address	
City, State, Zip	
Main Phone	Alternate Phone
Social Security #	
Date of Birth	❑ Male ❑ Female

PRESCRIBER INFORMATION

Prescriber Name		
DEA #	NPI #	License #
Address		
City, State, Zip		
Phone	Fax	
Contact Person		

INSURANCE: PLEASE FAX COPY OF PRESCRIPTION CARD & MEDICAL CARD FRONT & BACK

CLINICAL INFORMATION

Diagnosis Code: ❑ 714.0 Rheumatoid Arthritis ❑ 733.0 Osteoporosis ❑ 555.0 Crohn's Disease ❑ Other: _____ DX Code: _____
❑ 696.0 Psoriatic Arthritis ❑ 696.1 Psoriasis Moderate to Severe Plaque ❑ 720.0 Ankylosing Spondylitis

Prior Failed Meds: ❑ Methotrexate Length of Treatment _____ ❑ Reason for Discontinuing _____
❑ _____ Length of Treatment _____ ❑ Reason for Discontinuing _____
❑ _____ Length of Treatment _____ ❑ Reason for Discontinuing _____

Forteo/Prolia: T-Score _____ Type _____ Date _____ Fracture History: Site _____ Date _____ Site _____ Date _____

Does patient have a latex allergy? ❑ Yes ❑ No TB/PPD Test given or intended to be given before start? ❑ Yes ❑ No

PRESCRIPTION INFORMATION

❑ Humira®	❑ 40mg Pen ❑ 40mg Prefilled Syringe	❑ Inject 40mg subcutaneously every OTHER week ❑ Inject 40mg subcutaneously ONCE a week	4 Week Supply	_____
❑ Enbrel®	❑ 50mg Sureclick ❑ 50mg Prefilled Syringe ❑ 25mg Prefilled Syringe ❑ 25mg Vials	❑ Inject 50mg subcutaneously ONCE a week ❑ IInject 25mg subcutaneously TWICE a week 72-96 hours apart	4 Week Supply	_____
❑ Cimzia®	❑ 200x2 Prefilled Syringe ❑ 200x2 LYO Powder	❑ Initial: Inject 400mg subcutaneously at weeks 0, 2 and 4 ❑ Maintenance: Inject 400mg SubQ once every 4 wks or ❑ Inject 200mg SubQ once every 2 wks	4 Week Supply	_____
❑ Simponi®	❑ 50mg SmartJect ❑ 50mg Prefilled Syringe ❑ Aria	❑ Inject 50mg subcutaneously ONCE a MONTH as directed ❑ Infuse _____mg at weeks 0 and 4, then every 8 weeks thereafter	4 Week Supply	_____
❑ Stelara®	❑ 45mg Prefilled Syringe	❑ Inject 45mg on day 0, then week 4, then every 12 weeks	4 Week Supply	_____
❑ Remicade®	❑ 100mg Vial	❑ Infuse _____mg at _____	4 Week Supply	_____
❑ Otezla®	❑ Starter Pack ❑ 30mg Tablets	❑ Titration: Take 1 tablet on day 1 then twice daily as directed ❑ Take 1 tablet by mouth twice daily	1 Starter Pack 60	None _____
❑ Prolia®	❑ 60mg Syringe	❑ Inject 60mg subcutaneously once every 6 months	4 Week Supply	_____
❑ Orencia®	❑ 125mg Prefilled Syringe ❑ 250mg Vials	❑ Inject 125mg subcutaneously ONCE a week ❑ Infuse _____mg at _____	4 Week Supply	_____
❑ Xeljanz®	❑ 5mg Tablets	❑ Take 1 tablet by mouth twice daily	60	_____
❑ Actemra®	❑ 162mg Prefilled Syringe ❑ _____ Vial	❑ Inject 162mg subcutaneously ❑ ONCE a week or ❑ every OTHER week ❑ Infuse _____mg at _____	4 Week Supply	_____

Prescriber's Signature (no stamps) **If Brand required check ❑ DAW** **Date**

By signing this form and utilizing our services, you are authorizing Blake Pharmacy and it's emplyees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

REV-6.17.15