MID-WEST MEDICAL SPECIALTY PHARMACY
8733 BEVERLY BLVD., LOS ANGELES, CA 90048

RHEUMATOLOGY FORM

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Today's Date:__________ Needs By Date:__________ SHIP TO: ❑ Patient ❑ Office ❑ Other__________

PATIENT INFORMATION		PRESCRIBER INFORMATION	
PATIENT NAME		PRESCRIBER NAME	
ADDRESS		NPI#	
CITY, STATE, ZIP		DEA#	LICENSE#
MAIN PHONE#	ALT.#	ADDRESS	
SOCIAL SECURITY#		CITY, STATE, ZIP	
DATE OF BIRTH	❑ MALE ❑ FEMALE	PHONE#	FAX#
HEIGHT WEIGHT	❑ LBS ❑ KG		
ALLERGIES		CONTACT PERSON	
OTHER MEDICATIONS			

CLINICAL INFORMATION

Diagnosis: ❑ M06.9 Rheumatoid Arthritis ❑ L40.59 Psoriatic Arthritis ❑ M81.0 Osteoporosis ❑ M45.9 Ankylosing Spondylitis ❑ K50.00 Crohn's Disease ❑ Other:__________

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			QUANTITY	REFILLS
❑ Actemra®	❑ 162mg/0.9ml Prefilled Syringe	Inject 1 syringe SC ❑ Every Week ❑ Every Other Week		
❑ Cimzia® Starter Dose ❑ Cimzia® Maintenance	❑ 200mg Starter Kit (contains 6, 200mg PFS) ❑ 2 x 200mg Prefilled Syringe	❑ Starter: Inject 400mg SC once, then repeat at weeks 2 and 4 ❑ Maintenance: ❑ 200mg SC ONCE every TWO weeks ❑ 400mg SC ONCE every FOUR weeks		
❑ Cosentyx® Starter Dose ❑ Cosentyx® Maintenance	❑ 150 mg/ml Sensoready Pen ❑ 150 mg/ml Pre-filled Syringe	❑ Starter: Inject 150mg SQ on week 0, 1, 2, 3, and 4 (Quantity: 5) ❑ Maintenance: Inject 150mg SQ every 4 weeks ❑ Starter: Inject 300 mg SQ on week 0, 1, 2, 3, and 4 (Quantity: 10) ❑ Maintenance: Inject 300mg SQ every 4 weeks		
❑ Enbrel®	❑ 50mg/ml SureClick™ Autoinjector ❑ 50mg/ml Prefilled Syringe ❑ 25mg/0.5ml Prefilled Syringe	❑ Inject 50mg SC ONCE a week ❑ Inject 25mg TWICE a week, 72 to 96 hours apart ❑ Other:__________		
❑ Forteo®	❑ 600mcg/2.4ml PFS	❑ Inject 20mcg SC, as directed, once daily		
❑ Humira®	❑ 40mg/0.8ml Pen ❑ 40mg/0.8ml Prefilled Syringe	❑ Inject 40mg SC every OTHER week ❑ Inject 40mg SC ONCE a week		
❑ Tymlos™ ❑ Pen *Needles Required	❑ 1 carton (1x3120mcg/1.56ml) ❑ 3 cartons (1x3120mcg/1.56ml) ❑ Pen needles -1 Box of 30	❑ Inject 80 mcg SQ once daily ❑ Use one needle daily with injection		
❑ Orencia®	❑ 125mg/ml Prefilled Syringe (4 syringes)	❑ Inject 125mg SC ONCE weekly		
❑ Otezla®	❑ Starter Pack (Titration) Rx for Otezla ❑ Maintenance Rx — 30 mg of Otezla ❑ Bridge Rx — 30 mg of Otezla	❑ x28 days 55 tablets ❑ x14 days 27 tablets ❑ Twice Daily ❑ Once Daily (pts. with severe renal impairment) ❑ Twice Daily ❑ Once Daily (pts. with severe renal impairment)	 ❑ x30 ❑ x90 ❑ x14 ❑ x28	
❑ Otrexup®	❑ 10mg Auto Injector ❑ 12.5mg Auto Injector ❑ 15mg Auto Injector ❑ 17.5mg Auto Injector ❑ 20mg Auto Injector ❑ 22.5mg Auto Injector ❑ 25mg Auto Injector	❑ Inject ml SQ every week		
❑ Rasuvo®	❑ 7.5mg Auto Injector ❑ 10mg Auto Injector ❑ 12.5mg Auto Injecto ❑ 15mg Auto Injector ❑ 17.5mg Auto Injector ❑ 20mg Auto Injector ❑ 22.5mg Auto Injecto ❑ 25mg Auto Injector ❑ 27.5mg Auto Injector ❑ 30mg Auto Injector	❑ Inject ml SQ every week		
❑ Simponi®	❑ 50mg/0.5ml Prefilled Syringe ❑ 50mg/0.5ml Autoinjector	❑ Inject 50mg ONCE a month ❑ Inject 50mg ONCE a month		
❑ Stelara®	❑ 45mg/0.5ml Prefilled Syringe ❑ 90mg/ml Prefilled Syringe ❑ 45mg/0.5ml Single-dose Vial	❑ Starter Dose: Inject 45mg SQ on Day 0 and Day 28 ❑ Maintenance: Inject 45mg SQ every 12 weeks ❑ Starter Dose: Inject 90mg SQ on Day 0 and Day 28 ❑ Maintenance: Inject 90mg SQ every 12 weeks		
❑ Xeljanz®	❑ 5mg ❑ 11mg (Extended Release Tablets)	❑ Take 1 tablet by mouth TWICE daily		
❑ Other:				

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

By signing this form and utilizing our services, you are authorizing Mid-West Medical Pharmacy and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

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

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