Ochsner Specialty Pharmacy

1405 Jefferson Hwy Suite A
New Orleans, LA 70121
Phone: (504)842-7439
1-855-312-4193
Fax: (504)842-5999

Rheumatology

PATIENT INFORMATION:

Patient Name:_____
Date of Birth:_____Male: ☐ Female: ☐
Address:_____
City/State/Zip:_____
Tel:_____Alt Tel:_____
SS#:_____Wt:_____Ht:_____

NKDA: ☐ Allergy:_____

INSURANCE INFORMATION:

Primary Pharmacy Insurance_____
Member Name:_____
Member ID:_____
Rx Group #:_____
BIN#_____PCN#_____
Customer Service #:_____

Please attach a copy of the front and back of the patient's insurance card, if available.**

DIAGNOSIS AND CLINICAL INFORMATION:

Diagnosis: ☐ M06.9 Rheumatoid Arthritis ☐ M45.9 Ankylosing Spondylitis ☐ M32.10 Systemic Lupus Erythematosus ☐
☐ L40.50 Psoriatic Arthritis ☐ Other:_____
Prior Med Failed: _methotrexate_____ Length of Treatment:_____Reason for D/C:_____
_____ Length of Treatment:_____Reason for D/C:_____
_____ Length of Treatment:_____Reason for D/C:_____
Forteo T-score:_____Type:_____Date:_____ Site
Fractured:_____Date:_____ ☐
TB/PPD test: ☐ Pos ☐ Neg Date Read:_____ ☐

PRESCRIBER INFORMATION:

Prescriber Name:_____Specialty:_____Date:_____
Address:_____City/State/Zip:_____
Contact Name:_____Phone #:_____Fax #:_____
NPI#:_____DEA #:_____UPIN #:_____

By signing this form and using our services, you are authorizing Ochsner Specialty Pharmacy to serve as your prior authorization designated agent in dealing with prescription and medical insurance companies. Prescriber Signature Below: (*Physician attests this is his/her legal signature.* **NO STAMPS**)

_____ _____
Substitution Allowed *Dispense as Written*

PRESCRIPTION:

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Actemra®	☐ 162mg PFS	☐ Inject 162mg every other week (under 100kg) ☐ Inject 162mg every week (over 100kg)	☐ 1 month supply	_____
☐ Benlysta®	☐ 120 mg/5ml ☐ 400mgmg/20ml	☐ Infuse __mg at weeks 0,2, and 4, then every 4 weeks therafter ☐ Infuse ___mg every 4 weeks	☐ 1 month supply	_____
☐ Cimzia®	☐ 200MG X2 PFS	☐ Inject 400mg SC at weeks 0, 2, and 4 ☐ Inject 400mg once monthly ☐ Inject 200mg every other week	☐ 1 month supply	_____
☐ Cosentyx®	☐ 150mg/ml Sensoready® ☐ 150mg/ml PFS ☐ 150mg lypholized powder	☐ Inject 150mg at weeks 0, 1, 2, 3, and 4 ☐ Inject 150mg every 4 weeks	☐ 1 month supply	_____
☐ Enbrel®	☐ 50mg Sureclick ☐ 50mg PFS ☐ 25mg Vials ☐ 25mg PFS	☐ Inject 50mg once weekly ☐ Inject 50mg twice weekly ☐ Inject 25mg once weekly ☐ Inject 25mg twice weekly	☐ 1 month supply	_____
☐ Forteo®	☐ 750µg/3ml pen and supplies	☐ Inject 20 µg SubQ once daily	☐ 1 month supply	_____
☐ Humira®	☐ 40mg Pen ☐ 40mg PFS	☐ Inject 40mg SubQ once a week ☐ Inject 40mg SubQ every other week	☐ 1 month supply	_____
☐ Methotrexate	☐ 2.5mg tab ☐ 25mg/ml vial	☐ Take _____mg by mouth once weekly ☐ Inject _____mg SubQ once weekly	☐ 1 month supply	_____
☐ Orencia®	☐ 125mg PFS ☐ 250mg Vial	☐ Inject 125mg once weekly ☐ Inject _____mg once monthly	☐ 1 month supply	_____
☐ Otezla®	☐ 30mg ☐ Starter Pack	☐ Take 1 tablet by mouth twice daily ☐ Take as per package instructions	☐ 1 month supply	_____
☐ Otrexup®	☐ _____mg/0.4ml	☐ Inject _____mg once weekly	☐ 1 month supply	_____
☐ Prolia®	☐ 60mg PFS	☐ Inject 60mg SubQ once every 6 months	☐ 1 month supply	_____
☐ Rasuvo®	☐ _____mg	☐ Inject _____mg once weekly	☐ 1 month supply	_____
☐ Simponi®	☐ 50mg Smartject ☐ 50mg PFS	☐ Inject 50mg SubQ once monthly	☐ 1 month supply	_____
☐ Stelara®	☐ 45mg PFS ☐ 90mg PFS	☐ Inject 45mg day 1 and week 4, then inject 45 every 12 weeks ☐ Inject 90mg day 1 and week, then inject 90mg every 12 weeks	☐ 1 month supply	_____
☐ Xeljanz®	☐ 5mg tablet ☐ XR 11mg tablet	☐ Take 1 tablet by mouth twice daily ☐ Take 1 tablet by mouth once daily	☐ 1 month supply	_____
☐ Other	_____	_____	_____	_____