Publix Specialty Pharmacy #3213
RHEUMATOLOGY

1950 Sand Lake Road, Bldg 5
Orlando, FL 32809
Phone: 855-797-8254
Fax: 863-413-5723

PATIENT INFORMATION [Attach copy of front and back of prescription insurance card(s)]

Patient's First Name: _____ Patient's Last Name: _____ Date of Birth: ___/___/_____ ☐Male ☐Female

Address: _____ City: _____ State: _____ Zip: _____

Primary Phone Number: (_____) _____ Alt. Phone Number: (_____) _____ Caregiver name: _____

CLINICAL INFORMATION [Attach copy of labs and clinical notes]

Diagnosis code: _____ Diagnosis: ☐Rheumatoid Arthritis ☐Ankylosing Spondylitis ☐Other: _____

Treatment status: ☐New to therapy ☐Continuation of therapy, start date: ___/___/____

Previously denied by insurance? ☐No ☐Yes, include copy of denial letter

Is the patient on samples? ☐No ☐Yes

Weight: _____ ☐kg ☐lb

Height: _____ ☐cm ☐in

TB test result (within 6 months): ☐N/A ☐Negative ☐Positive, Date of TB test: ___/____/_____ Allergies: ☐ NKDA ☐Other: _____

Prior therapy, treatment dates, and reason for discontinuation: _____

MEDICATION	DOSE/STRENGTH	DIRECTIONS	DISPENSE	REFILLS
☐ Actemra (tocilizumab)	☐162 mg/0.9 mL ACTPen ☐162 mg/0.9 mL prefilled syringe (PFS) Patient weight: _____	☐<100kg: Inject 162 mg SC every 2 weeks ☐≥100kg: Inject 162 mg SC once a week	☐28 days ☐84 days	_____
☐ Cimzia (certolizumab pegol)	☐Starter Kit: 6 x 200 mg/mL PFS ☐200 mg vial	Initial Dose: Inject 400 mg SC on days 1, 15, and 29	3 doses (6 PFS/vials)	0
	☐200 mg/mL PFS ☐200 mg vial	Maintenance Dose: ☐Inject 400 mg SC every 4 weeks ☐Inject 200 mg SC every 2 weeks	☐28 days ☐84 days	_____
☐ Cosentyx (secukinumab)	☐150 mg/mL Sensoready pen ☐150 mg/mL PFS	Initial Dose: ☐Inject 150 mg SC once a week for 5 weeks (on days 1, 8, 15, 22, and 29)	5 doses	0
		Maintenance Dose: ☐Inject 150 mg SC every 4 weeks	☐28 days ☐84 days	_____
☐ Enbrel (etanercept)	☐50 mg/mL Mini cartridge ☐50 mg/mL PFS ☐50 mg/mL SureClick pen ☐25 mg/0.5 mL PFS	☐Inject 50 mg SC ONCE a week ☐Inject 25 mg SC TWICE a week (3-4 days apart)	☐28 days ☐84 days	_____
☐ Humira (adalimumab)	☐40 mg/0.4mL pen (citrate-free) ☐40 mg/0.8mL pen ☐40 mg/0.4mL PFS (citrate-free) ☐40 mg/0.8mL PFS	☐Inject 40 mg SC every 2 weeks ☐Inject 40 mg SC once a week	☐28 days ☐84 days	_____
☐ Kevzara (sarilumab)	☐200 mg/1.14 mL pen ☐150 mg/1.14 mL pen ☐200 mg/1.14 mL PFS ☐150 mg/1.14 mL PFS	Inject 1 dose SC every 2 weeks	☐28 days ☐84 days	_____
☐ Olumiant (baricitinib)	2 mg tablet	Take 1 tab PO once daily with or without food	☐30 days ☐90 days	_____
☐ Orencia (abatacept)	☐125 mg/mL ClickJect pen ☐125 mg/mL PFS	Inject 125 mg SC once a week	☐28 days ☐84 days	_____
☐ Rinvoq (upadacitinib)	15 mg tablet	Take 1 tab PO once daily with or without food	☐30 days ☐90 days	_____
☐ Simponi (golimumab)	☐50 mg/0.5 mL SmartJect pen ☐50 mg/0.5 mL PFS	Inject 50 mg SC every 4 weeks	☐28 days ☐84 days	_____
☐ Taltz (ixekizumab)	☐80 mg/mL Pen ☐80 mg/mL PFS	Initial Dose: ☐Inject 160 mg SC once on day 1	1 dose (2 pens/PFS)	0
		Maintenance Dose: ☐Inject 80 mg SC every 4 weeks starting on day 29	☐28 days ☐84 days	_____
☐ Xeljanz (tofacitinib)	☐5 mg tablet	Take 1 tab PO BID with or without food	☐30 days ☐90 days	_____
	☐11 mg XR tablet	Take 1 tab PO once daily with or without food		
☐ Other: _____	_____	_____	_____	_____

PRESCRIBER INFORMATION [Ship to prescriber: ☐ Never ☐Always ☐First fill only, appointment date: ___/___/_____ Using Cover My Meds: ☐No ☐Yes]

Name: _____ DEA# _____ NPI # _____

Address: _____ City: _____ State: _____ Zip: _____

Office Phone Number: (_____) _____ Fax Number: (_____) _____ Office Contact: _____

I authorize Publix Pharmacy representatives to act on behalf of the prescriber to initiate and complete the insurance prior authorization process.

For states requiring hand written expressions to prevent substitution, write here:

Prescriber's signature: _____ _____
(stamps not accepted)

☐Substitution allowed Date ☐Dispense as written/ Do not substitute Date