

RHEUMATOID ARTHRITIS

TELEPHONE 1-800-237-2767 FAX 1-800-323-2445

1. PATIENT INFORMATION *To be completed by the patient*

Last Name		First Name		M.I.
Street Address				
City		State	ZIP	
Day Telephone # (+Area Code)		Night Telephone # (+Area Code)		Mobile Telephone # (+Area Code)
Date of Birth (MM/DD/YYYY)	Social Security #		Sex (Check One) <input type="checkbox"/> M <input type="checkbox"/> F	
Parent/Guardian Name				

INSURANCE INFORMATION

Primary/Medical Insurance		Secondary/Pharmacy Insurance		
Cardholder Name & ID # (If Not Patient)		Cardholder Name & ID # (If Not Patient)		
Group/Policy #		Group/Policy #		
Insurance Telephone # (+Area Code)		Insurance Telephone # (+Area Code)		
Employer		Medicaid #		

ALTERNATE SHIPPING ADDRESS

Last Name		First Name		M.I.
Street Address		City	State	ZIP

Caremark is committed to protecting the privacy of your health information. We will hold your health information in confidence and will only use and disclose it in accordance with applicable law.

2. PHYSICIAN INFORMATION *To be completed by the physician and staff*

Prescriber's Last Name		Prescriber's First Name		
Hospital/Clinic		Office Contact		
Street Address				
City		State	ZIP	
Telephone # (+Area Code)		Fax # (+Area Code)		E-Mail Address
Prescriber's License #		DEA #	NPI #	
UPIN#		Medicaid License #		

STATEMENT OF MEDICAL NECESSITY

PRIMARY DIAGNOSIS: (ICD-9 CM Code Plus Description)
 714.0 Rheumatoid Arthritis Other _____ Date of Diagnosis: / /
 TB Test Performed? Yes No If Yes, Results:
 Comments:
 Has Patient Been Diagnosed with Lymphoma? Yes No
 Does Patient Have Chronic/Localized Infection? Yes No
 Has Patient Been Diagnosed with Congestive Heart Failure? Yes No
 Has Patient Tried and Failed 8-12 Weeks with a DMARD Agent? Yes No
 DMARDs Tried and Failed:
 Contraindications to DMARD? Yes No
 List:

INJECTION TRAINING:

Injection Training Will Be/Has Been Conducted by the Physician's Office?
 Yes No Date: / /
 First Dose of Medication Will Be/Has Been Administered at Physician's Office?
 Yes No Date: / /
 Comments:

Rx
Patient Weight _____ kg. **OR** _____ lbs.
Drug Allergies _____
 NKDA
 Enbrel® 50 mg SureClick™ Autoinjector 50 mg Prefilled Syringe 25 mg Vial
 Quantity:
 SIG: 50 mg SQ QW or 25 mg SQ BIW Other:
 Humira® 40 mg Prefilled Pen 40 mg Prefilled Syringe Quantity:
 SIG: 40 mg SQ Every Other Week Other:
 Kineret® 100 mg Prefilled Syringe Quantity:
 SIG: 100 mg QD Other:
 Orencia® 250 mg Vial Quantity:
 SIG: Infuse _____ mg in 100 ml of 0.9% NaCl as Directed
 Other: _____ Freq:
 Home Health Nurse to Administer
 Remicade® 100 mg Vial Quantity:
 SIG: Infuse 3 mg/kg in 250 ml of 0.9% NaCl as Directed
 Other: _____ Freq:
 Home Health Nurse to Administer
 Rituxan® 500 mg Vial Quantity:
 SIG: Infuse 1000 mg in 1 Liter of 0.9% NaCl as Directed
 Other: _____ Freq:
 Home Health Nurse to Administer

Ancillary Supplies and Kits Provided As Needed for Administration.
Other Prescriber's Notes:
 Refill _____ Times
 Dispense As Written Substitution Allowed
Prescriber's Signature _____ **Date** _____

PHYSICIAN SPECIALTY: Rheumatologist Other (Specify)

3. FAX COMPLETED FORM TOLL-FREE TO CAREMARKCONNECT® @ 1-800-323-2445
Please include copies of the patient's insurance cards (front & back) when faxing the referral to expedite benefit clearance.
Thank you for choosing Caremark!