

PATIENT INFORMATION	PHYSICIAN INFORMATION
Patient Name: _____	Physician Name: _____
Address: _____	Contact: _____
City, State, Zip: _____	NPI #: _____
Phone #: _____ Secondary Phone #: _____	Address: _____
Patient SSN#: _____ Date of Birth: _____	_____
Weight (lbs): _____ Height (in.): _____ Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	City, State, Zip Code
Allergies: _____	Phone #: _____
Primary Insurance: _____	Alt Phone #: _____
ID#: _____ Phone #: _____	Fax #: _____
Secondary Insurance: _____	Email: _____
ID#: _____ Phone #: _____	Ship Rx to: <input type="checkbox"/> Physician's Office <input type="checkbox"/> Patient's home
<b>FAX COPY OF INSURANCE CARD (FRONT &amp; BACK)</b>	

CLINICAL INFORMATION		
<p style="text-align: center;">ICD-10 Diagnosis</p> <input type="checkbox"/> M06.9 Rheumatoid Arthritis <input type="checkbox"/> M08.0 Juvenile Idiopathic Arthritis <input type="checkbox"/> L40.59 Psoriatic Arthritis <input type="checkbox"/> L40.54 Psoriatic Juvenile Arthritis <input type="checkbox"/> M45.9 Ankylosing Spondylitis	Date of Diagnosis: _____ Date of negative TB test: _____ Comorbidities: _____ Medication Reconciliation: _____ _____	
Prior Treatment/Therapy (If Any)	Reason for Discontinuation	Start and End Date of Therapy
_____	_____	_____
_____	_____	_____
_____	_____	_____
<b>FAX COPY OF ALL RELATED CLINICAL/LAB INFO</b>		

MEDICATION	DIRECTIONS	QTY	REFILLS
<input type="checkbox"/> ACTEMRA®	<input type="checkbox"/> Inject 162 mg subcutaneously every other week (<100 kg) <input type="checkbox"/> Inject 162 mg subcutaneously every week (≤100 kg)	<input type="checkbox"/> 2 PFS <input type="checkbox"/> 4 PFS	
<input type="checkbox"/> CIMZIA®	Starter: <input type="checkbox"/> Inject 400 mg subcutaneously on weeks #1, 2, 4 Maintenance: <input type="checkbox"/> Inject 400 mg subcutaneously every 4 weeks <input type="checkbox"/> Inject 200 mg subcutaneously every 2 weeks	1 Carton (2x200 mg): <input type="checkbox"/> PFS <input type="checkbox"/> Vials	
<input type="checkbox"/> COSENTYX®	To order Cosentyx® please see the Novartis service request form at <a href="http://cosentyxhcp.com/get-your-patients-started">cosentyxhcp.com/get-your-patients-started</a> Please choose 'Delta Drugs' as the preferred specialty pharmacy to ensure medication is sent to Delta Drugs.		
<input type="checkbox"/> ENBREL®	<input type="checkbox"/> Inject 50 mg subcutaneously every week <input type="checkbox"/> _____	<input type="checkbox"/> 1 Carton (4x50mg/mL) <input type="checkbox"/> _____ <input type="checkbox"/> PFS <input type="checkbox"/> Vials <input type="checkbox"/> SureClick®	
Injection Training Provided By: <input type="checkbox"/> Physician's Office <input type="checkbox"/> Delta Drugs   <input type="checkbox"/> Dispense As Written			

Physician's Signature: _____	Date: _____
<b>I AUTHORIZE DELTA DRUGS AND ITS REPRESENTATIVES TO ACT AS AN AGENT TO INITIATE AND EXECUTE THE INSURANCE PRIOR AUTHORIZATION PROCESS.</b>	