BROADWAY SPECIALTY PHARMACY

RHEUMATOLOGY

Fax: 833.803.3110
Phone: 800.640.8207
broadwayrx.health

1. PATIENT INFORMATION

****PLEASE FAX COPY OF: PRESCRIPTION CARD FRONT & BACK and CLINICAL NOTES/LABS****

NAME:		ADDRESS:	CITY:	STATE:	ZIP:
DOB:	SEX: ☐ F ☐ M	PHONE:	CELL PHONE:	SSN:	
HEIGHT:	WEIGHT:	HIPAA CONTACT/CAREGIVER:	ALLERGIES: ☐ LATEX ☐ NKDA		

2. CLINICAL INFORMATION

DATE OF DIAGNOSIS: _____ HISTORY: ☐ NEW ☐ RESTART ☐ CONTINUING | TB TEST: NEGATIVE DATE _____ HBV NEGATIVE OR TREATED: ☐ YES ☐ NO

DIAGNOSIS / ICD-10: ☐ RHEUMATOID ARTHRITIS (M06..9) ☐ PSORIATIC ARTHRITIS (L40.5) ☐ ANKYLOSING SPONDYLITIS (M45.9) ☐ JIA (M08.0) ☐ PSORIATIC JUVENILLE ARTHRITIS (L40.54) ☐ OTHER_____

RAPID-3 SCORE: _____	MHAQ SCORE: _____	CURRENT THERAPY:	COMORBIDITIES:

FAILED TREATMENTS:	** ENTER LENGTH OF TREATMENT AND DATES BELOW/BESIDE FAILED THERAPY **
BIOLOGICS	☐ CIMZIA ☐ COSENTYX ☐ ENBREL ☐ HUMIRA ☐ ORENCIA ☐ REMICAID ☐ RITUXAN ☐ SIMPONI ☐ STELARA ☐ TALTZ
DMARDs	☐ AZATHIOPRINE ☐ LEFLUNOMIDE ☐ METHOTREXATE ☐ PLAQUENIL ☐ SULFASALAZINE ☐ RASUVO / OTREXUP ☐ _____
OTHERS	☐ OTEZLA _____ ☐ XELJANZ _____ ☐ CORTICOSTEROIDS _____ ☐ INDOCIN _____ ☐ _____

NOTES:

3. Rx

IF SHIPPING TO PRESCRIBER: ☐ FIRST FILL ☐ ALL FILLS | PATIENT RECEIVED STARTER DOSE: ☐ YES: DATE _____ ☐ NO

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ ACTEMRA®	o 162mg/ml PFS	o Inject 162mg Sub-Q EVERY OTHER week (<100kg) o Inject 162mg Sub-Q ONCE a week (>100kg)	4-Week Supply	_____
☐ CIMZIA®	o 200mg/ml PFS o 200mg/ml LYO Powder	o Loading Dose: Inject 400mg Sub-Q at weeks 0, 2, and 4 o Maintenance Dose: Inject 400mg Sub-Q every 4 weeks o Maintenance Dose: Inject 200mg Sub-Q every 2 weeks	1 Starter Kit 4-Week Supply	None _____
☐ COSENTYX®	o 150mg/ml PFS o 150mg/ml Sensoready Pen	o Loading Dose: Inject Sub-Q weeks 0, 1, 2, 3, 4 o 150mg o 300mg o Maintenance Dose: Inject Sub-Q every 4 weeks o 150mg o 300mg	5-Week Supply 4-Week Supply	None _____
☐ ENBREL®	o 25mg/0.5ml PFS o 25mg Vial o 50mg/ml Mini Cartridge o 50mg/ml PFS o 50mg/ml Sureclick	o Inject 50mg Sub-Q ONCE a week o Inject 25mg Sub-Q TWICE a week (72-96 hours apart) o Pediatric Dose < 138lb(63kg) Inject 0.8mg/kg (_____mg) Sub-Q ONCE a week o Other: _____	4-Week Supply	_____
☐ HUMIRA®	o 40mg Pen o 40mg PFS	o Inject 40mg Sub-Q ONCE a week o Inject 40mg Sub-Q EVERY OTHER week	4-Week Supply	_____
☐ KEVZARA®	o 150mg PFS o 200mg PFS	o Inject 150mg Sub-Q every 2 weeks o Inject 200mg Sub-Q every 2 weeks	4-Week Supply	_____
☐ ORENCIA®	o 125mg/ml ClickJect o 125mg/ml PFS	o Inject 125mg Sub-Q once a week	4-Week Supply	_____
☐ OTEZLA®	o Starter Pack o 30mg Tablets	o Loading Dose: Take 1 tablet on day 1, then twice daily as directed. o Maintenance Dose: Take 1 tablet by mouth twice daily.	1 Starter Pack 60	None _____
☐ SIMPONI®	o 50mg/0.5ml SmartJect o 50mg/0.5ml PFS	o Inject 50mg Sub-Q once a month	4-Week Supply	_____
☐ STELARA® WT:_____	o 45mg/ml Vial o 45mg PFS (<100kg/220lbs) o 90mg PFS (>100kg/220lbs)	o Loading Dose: <60kg(132lbs) Inject 0.75mg/kg (_____mg) Sub-Q on day 1 o Loading Dose: Inject 1 PFS Sub-Q on day 1 o Maintenance: Inject the contents of 1 PFS Sub-Q on day 29 then every 12 weeks	1	None None _____
☐ TALTZ®	o 80mg/mL Autoinjector o 80mg/mL PFS	o Loading Dose: (Psoriatic Arthritis): Inject 160 mg Sub-Q on day 1 o Maintenance Dose: Inject 80mg Sub-Q every 4 weeks	2 4-Week Supply	None _____
☐ XELJANZ® ☐ XELJANZ XR®	o 5mg Tablet o 11mg Tablet	o Take one tablet by mouth twice daily o Take one tablet by mouth once daily	60 30	_____ _____
☐				
☐				

4. PRESCRIBER INFORMATION

UPON PA DENIAL: ☐ SEND FORMULARY ALTERNATIVES ☐ DRAFT APPEAL

PRESCRIBER SIGNATURE: I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment. By signing this form and utilizing our services, you are authorizing Broadway Pharmacy and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies and Co-Pay Assistance/Foundations.

Signature: _____ Date: _____ Signature: _____ Date: _____

Substitution Permitted — Dispense As Written

PRESCRIBER NAME:	ADDRESS:		CITY:	STATE:	ZIP:
OFFICE CONTACT:	PHONE:	FAX:	NPI:	DEA:	

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