

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		
ICD-10 Diagnosis <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"/> HUMIRA®	<input type="checkbox"/> Inject 40 mg SQ every other week ( $\geq 30$ kg) <input type="checkbox"/> Inject 40 mg SQ once a week ( $\geq 30$ kg) <input type="checkbox"/> Inject 20 mg SQ every other week (15 to $<30$ kg) <input type="checkbox"/> Inject 10 mg SQ every other week (10 to $<15$ kg)	<input type="checkbox"/> 1 carton (2x40 mg/0.8 mL Pens) <input type="checkbox"/> 2 carton <input type="checkbox"/> 1 carton (2x40 mg/0.8 mL PFS) <input type="checkbox"/> 2 carton <input type="checkbox"/> 1 carton (2x20 mg/0.8 mL PFS) <input type="checkbox"/> 1 carton (2x10 mg/0.8 mL)	
<input type="checkbox"/> ORENCIA® (JIA $<75$ KG) ONLY	Starter: <input type="checkbox"/> Infuse 10 mg/kg at weeks 0 and 2 Maint.: <input type="checkbox"/> Infuse 10 mg/kg at week 4 and every 4 weeks thereafter	_____ vials (250 mg/vial) _____ vials (250 mg/vial)	
<input type="checkbox"/> ORENCIA®	Starter: <input type="checkbox"/> Infuse weight-range at week 0 Only Maint.: <input type="checkbox"/> Inject 1 PFS (125 mg) SQ once weekly <input type="checkbox"/> Infuse weight-range based at week 4 and every 4 weeks Starter: <input type="checkbox"/> Infuse weight-range based at weeks 0 and 2	<input type="checkbox"/> 2 vials ( $<60$ kg) <input type="checkbox"/> 3 vials (60-100 kg) <input type="checkbox"/> 4 vials ( $>100$ kg) <input type="checkbox"/> 4 PFS <input type="checkbox"/> 4 vials ( $<60$ kg) <input type="checkbox"/> 6 vials (60-100 kg) <input type="checkbox"/> 8 vials ( $>100$ kg)	
<input type="checkbox"/> OTEZLA®	Starter: <input type="checkbox"/> Take as directed per package instructions Maint.: <input type="checkbox"/> Take 30 mg by mouth twice daily <input type="checkbox"/> _____	55 tablets (one 28-day pack) 60 tablets <input type="checkbox"/> _____	
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: \_\_\_\_\_

**I AUTHORIZE DELTA DRUGS AND ITS REPRESENTATIVES TO ACT AS AN AGENT TO INITIATE AND EXECUTE THE INSURANCE PRIOR AUTHORIZATION PROCESS.**