

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"/> SIMPONI®	<input type="checkbox"/> Inject 50 mg subcutaneously once monthly	1 box (1x50 mg/0.5mL) <input type="checkbox"/> SmartJet™ <input type="checkbox"/> PFS	
<input type="checkbox"/> SIMPONI® ARIA™	Starter <input type="checkbox"/> Infuse 2mg/kg over 30 minutes at weeks 0	_____ vials (50 mg/ 4 ml vial)	
	Maint. <input type="checkbox"/> Infuse 2 mg/kg over 30 minutes at week 4 and every 8 weeks after	_____ vials (50 mg/ 4 ml vial)	
<input type="checkbox"/> STELARA®	Starter <input type="checkbox"/> Inject 45 mg/0.5 mL SQ on day 1 (≤100 kg/220 lbs) <input type="checkbox"/> Inject 90 mg/0.5 mL SQ on day 1 (≤100 kg/220 lbs)	<input type="checkbox"/> 1 PFS	
	Maint. <input type="checkbox"/> Inject 45 mg/0.5 mL SQ on day 29 an every 12 weeks thereafter (≤100 kg/220 lbs) <input type="checkbox"/> Inject 90 mg/0.5 mL SQ on day 29 and every 12 weeks thereafter (≤100 kg/220 lbs)		
<input type="checkbox"/> XELJANZ®	<input type="checkbox"/> Take 5 mg by mouth twice daily <input type="checkbox"/> _____	<input type="checkbox"/> 60 tablets <input type="checkbox"/> _____	
<input type="checkbox"/> XELJANZ® XR	<input type="checkbox"/> Take 11 mg by mouth twice daily	<input type="checkbox"/> 30 tablets	
<input type="checkbox"/> ZURAMPIC®	<input type="checkbox"/>	<input type="checkbox"/> 30 tablets	

Injection Training Provided By:  Physician's Office  Delta Drugs |  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>	