METIER PHARMACYCO.
Pharmacy Unscripted

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Ship To: ☐ Patient ☐ Physician/Clinic Date Shipment Needed: ____________ **Rx:** ☐ New ☐ Refill ____________

PATIENT INFORMATION

Patient's Full Name: ____________
Address: ____________
City, State, Zip: ____________
Home Phone: ____________ Alt. Phone: ____________
Patient SS#: ____________
DOB: ____________
Allergies: ____________
Gender: ☐ Male ☐ Female
Primary Insurance: ____________
ID#: ____________ Phone: ____________
Secondary Insurance: ____________
ID#: ____________ Phone: ____________

PLEASE FAX COPY OF INSURANCE CARD (FRONT & BACK)

- ☐ Rheumatoid Arthritis ☐ Ankylosing Spondylitis ☐ Juvenile RA (JIA) ☐ other
- Severity index: ☐ Mild ☐ Moderate ☐ Severe
- Has patient been treated previously for this condition? ☐ No ☐ Yes
  Medication/therapy failed (length of therapy): ____________
  Therapies: ____________
- Is patient currently in therapy? ☐ Yes ☐ No
  Type / Medications: ____________
- Will patient terminate current therapy upon start of new prescription? ☐ Yes ☐ No
- How long should the patient wait before starting the new drug therapy?
  ____
- Other medications patient is currently taking including OTC medications with dosage and direction (or fax medication profile):
  ____

Has patient received a PPD (tuberculosis) Skin Test? ☐ Yes ☐ No
Results: ____________ ICD-10 Code: ____________

MEDICATION	DOSE/STRENGTH	SIG	QTY.	REFILLS
☐ **Actemra**	☐ 162mg/0.9ml PFS	☐ Inject 1 syringe SC every week ☐ Inject 1 syringe SC every other week	4-week supply	
☐ **Cimzia Initial Dose**	☐ 200mg Starter Kit (contains 6, 200mg PFS)	☐ Inject 400mg SC once, then repeat at weeks 2 and 4	4-week supply	No Refills
☐ **Cimzia Maintenance Treatment**	☐ 2 x 200mg Prefilled Syringe	☐ 200mg SC ONCE every TWO weeks ☐ 400mg SC ONCE every FOUR weeks	4-week supply	
☐ **Cosentyx**	☐ 150mg/ml Sensoready Pen ☐ 150mg/ml Prefilled Syringe ☐ 150mg Lyophillized Powder SDV	☐ Induction Dose: 150 mg SC at Weeks 0, 1, 2, 3 and 4 and once every 4 weeks hereafter ☐ Maintenance Dose: 150 subq every 4 weeks ☐ Other	4-week supply	
☐ **Enbrel**	☐ 50mg/ml SureClick™ Autoinjector ☐ 50mg/ml Prefilled Syringe ☐ 25mg Prefilled Vial	☐ Inject 50mg SC ONCE a week ☐ Inject 25mg SC TWICE a week, 72 to 96 hours apart ☐ Other: ____________	4-week supply	
☐ **Humira**	☐ 40mg/0.8ml Pen ☐ 40mg/0.8ml Prefilled Syringe	☐ Inject 40mg SC every OTHER week ☐ Inject 40mg SC ONCE a week	4-week supply	
☐ **Orencia**	☐ 125mg/ml Prefilled Syringe (4 syringes)	☐ Inject 125mg SC ONCE weekly		
☐ **Otezla**	☐ Titration Pack or Date starter pack was provided ____ / ____ / ____ ☐ 30 mg	☐ Take as instructed according to the package instructions presented for 28 days ☐ 1 tablet twice daily	#55 #60	
☐ **Remicade**	☐ 100mg Vial # of Vials ____________			
☐ **Rituxan**	☐ 100mg Vial # of Vials ____________			
☐ **Simponi**	☐ 50mg/0.5ml Prefilled Syringe ☐ 50mg/0.5ml Autoinjector	☐ Inject 50mg SC ONCE a month	4-week supply	
☐ **Simponi, Aria**	☐ 50mg/4ml single use Vial	☐ Infuse ________ mg at week 0, 4 then every 8 weeks ☐ Infuse ________ mg every 8 weeks ☐ Other ____________		
☐ **Xeljanz**	☐ 5mg tablets	☐ Take 5mg by mouth TWICE daily	#60	
☐ **Other**				

PRESCRIBER INFORMATION

Physician's Name (Please Print): ____________ NPI #: ____________ **# of Prescriptions:** ______
Address: ____________ License #: ____________
City, State, Zip: ____________ DEA #: ____________
Phone: ____________ Fax: ____________ Contact Name: ____________
Physician's Signature: ____________ Date: ____________

I authorize Metier Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

IMPORTANT NOTICE- This message is intended for use of only the name addressee and may contain information that is proprietary and confidential. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to named addressee.

-This prescription form is valid only if faxed directly by the prescriber or his/her authorized representative. Original prescription drug orders can only be accepted directly from the patients.
-The prescriber attests that he/she has advised the patient with the option of choosing a pharmacy of his/her choice.