aetna®

Rheumatoid/ Psoriatic/ Juvenile Arthritis & Ankylosing Spondylitis Medication Request

Aetna Specialty Pharmacy®
503 Sunport Lane
Orlando, FL 32809

Customer Service: 1-866-782-ASRX (1-866-782-2779) **Fax Order Submission: 1-866-FAX-ASRX (1-866-329-2779)**

For your convenience, this medication request may be submitted via E-PRESCRIBE to Aetna Specialty Pharmacy

Aetna Specialty Pharmacy will verify benefits and contact members to confirm delivery before medication is shipped.

Today's Date: **Date Needed:**

A. PATIENT INFORMATION

First Name:	Last Name:	DOB:	
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	
Weight:	Height:	Allergies:	

B. INSURANCE INFORMATION

Carrier Name: _____ Does patient have other coverage? ☐ Yes ☐ No
Member ID #: _____ If yes, Carrier Name: _____
Group #: _____ Member ID#: _____
Insured: Insured:

Medicare: ☐ Yes ☐ No If yes, ID #: **Medicaid**: ☐ Yes ☐ No If yes, ID #:

C. PHYSICIAN INFORMATION

First Name:	Last Name: *(Check one):* ☐M.D. ☐D.O. ☐N.P. ☐ P.A.		
Address:	City:	State:	ZIP:
Phone: Fax:	DEA #: NPI #:	Office Contact:	

D. DIAGNOSIS

Primary ICD Code: Other ICD Code:

E. PRESCRIPTION

Please refer to the insurance carrier's participating provider precertification list to verify precertification requirements.

Medication	Directions	Quantity	Refills
☐ ACTEMRA ☐ 100ml NS BAG ☐ NS Flush	***DOSE:*** _____mg ***OR*** _____mg/kg (Wt: _____kg ***OR*** _____lbs) ☐ Infuse IV every 4 weeks ☐ Other:	☐ 1 month ☐ 3 months ☐ Other:	
☐ ACTEMRA 162mg PFS	☐ 162mg SQ every other week ☐ 162mg SQ every week ☐ Other:	☐ 1 month ☐ 3 months ☐ Other:	
☐ CIMZIA **Initial dose:** ☐ CIMZIA PFS STARTER KIT ☐ CIMZIA 200mg VIALS ☐ CIMZIA **Maintenance dose:** ☐ CIMZIA 200mg PFS ☐ CIMZIA 200mg VIALS	☐ **Loading dose:** 400mg SQ at week 0, week 2, and week 4 ☐ **Maintenance dose:** ☐ 400mg SQ every 4 weeks ☐ 200mg SQ every 2 weeks ☐ Other:	☐ Loading doses, ***then*** ☐ 1 month ☐ 3 months ☐ Other:	
☐ COSENTYX 150mg PEN ☐ COSENTYX 150mg PFS	☐ **Loading dose:** mg SQ at week 0,1,2 3 and 4 followed by, ☐ **Maintenance dose:** mg SQ every 4 weeks ☐ Other:	☐ Loading doses ***then:*** ☐ 1 month ☐ 3 months ☐ Other:	
☐ ENBREL 25mg ☐PFS ☐VIALS ☐ ENBREL 50mg ☐PEN ☐PFS ☐MINI CART	☐ 25mg SQ every week ☐ 25mg SQ twice a week ☐ 50mg SQ every week ☐ Other:	☐ 1 month ☐ 3 months ☐ Other:	
☐ HUMIRA 40mg/0.4ml ☐PEN ☐ PFS ☐ HUMIRA 40mg/0.8ml ☐PEN ☐ PFS ☐ HUMIRA 20mg/0.2ml PFS ☐ HUMIRA 20mg/0.4ml PFS ☐ HUMIRA 10mg/0.1ml PFS ☐ HUMIRA 10mg/0.2ml PFS	☐ 10mg SQ every other week ☐ 20mg SQ every other week ☐ 40mg SQ every other week ☐ 40mg SQ every week ☐ Other:	☐ 1 month ☐ 3 months ☐ Other:	

Ship to: ☐ Physician's Office ☐ Patient ☐ Other address:

*Interchange is mandated unless practitioner handwrites the words **"MEDICALLY NECESSARY"** for each medication.*

Prescriber's Signature **(Required by Law):**

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Member ID #: _____ If yes, Carrier Name: _____
Group #: _____ Member ID#: _____
Insured: Insured:

Medicare: ☐ Yes ☐ No If yes, ID #: **Medicaid**: ☐ Yes ☐ No If yes, ID #:

C. PHYSICIAN INFORMATION

First Name:	Last Name: *(Check one)*: ☐M.D. ☐D.O. ☐N.P. ☐ P.A.		
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D. DIAGNOSIS

Primary ICD Code: Other ICD Code:

E. PRESCRIPTION

Please refer to the insurance carrier's participating provider precertification list to verify precertification requirements.

Medication	Directions	Quantity	Refills
☐ INFLECTRA 100mg VIALS ☐ SWFI ☐ 250ml NS IV Bag ☐ NS Flush	***DOSE:*** _____mg ***OR*** _____mg/kg (Wt: _____kg ***OR*** _____lbs) ☐ **Loading dose:** Infuse IV at week 0, 2, and week 6; ***then:*** ☐ **Maintenance dose:** Infuse IV every _____ weeks ☐ Other:	☐ Loading doses ***then:*** ☐ 1 dose ☐ Other:	
☐ KEVZARA 150mg PFS ☐ KEVZARA 200mg PFS	☐ Inject SQ once every 2 weeks ☐ Other:	☐ 1 month ☐ 3 months ☐ Other:	
☐ METHOTREXATE 25mg/1mL INJECTION ☐ SDV ***OR*** ☐ MDV	***DOSE:*** _____mg ***ROUTE:*** ☐ SQ ☐ IM ☐ Inject once every week ☐ Other:	☐ 1 month ☐ 3 months ☐ Other:	
☐ ORENCIA ☐ 50mg PFS ☐ 87.5mg PFS ☐ 125mg ☐ PEN ☐ PFS	☐ 125mg SQ every week ☐ Other:	☐ 1 month ☐ 3 months ☐ Other:	
☐ ORENCIA 250mg VIALS ☐ SWFI ☐ 100ml NS IV Bag ☐ NS Flush	***DOSE:*** _____mg ☐ **Loading dose:** Infuse IV at week 0, week 2, and week 4; ***then:*** ☐ **Maintenance dose:** Infuse IV every 4 weeks ☐ Other:	☐ Loading doses ***then:*** ☐ 1 month ☐ 3 months ☐ Other:	
☐ OTEZLA STARTER PACK ☐ OTEZLA 30mg Tablets	☐ **Starter pack**: Take as per package instructions. ☐ 1 tablet by mouth twice daily ☐ Other:	☐ Starter pack ***then:*** ☐ 1 month ☐ 3 months ☐ Other:	
☐ OTREXUP PEN ☐ 7.5mg ☐ 10mg ☐ 12.5mg ☐ 15mg ☐ 17.5mg ☐ 20mg ☐ 22.5mg ☐ 25mg	☐ Inject SQ every week ☐ Other:	☐ 1 month ☐ 3 months ☐ Other:	
☐ RASUVO PEN ☐ 7.5mg ☐ 10mg ☐ 12.5mg ☐ 15mg ☐ 17.5mg ☐ 20mg ☐ 22.5mg ☐ 25mg ☐ 27.5mg ☐ 30mg	☐ Inject SQ every week ☐ Other:	☐ 1 month ☐ 3 months ☐ Other:	

Ship to: ☐ Physician's Office ☐ Patient ☐ Other address:

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Medicare: ☐ Yes ☐ No If yes, ID #: **Medicaid**: ☐ Yes ☐ No If yes, ID #:

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Phone:	Fax:	DEA #:	NPI #:	Office Contact:

D. DIAGNOSIS

Primary ICD Code: Other ICD Code:

E. PRESCRIPTION

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Medication	Directions	Quantity	Refills
☐ REMICADE 100mg VIALS ☐ SWFI ☐ 250ml NS IV Bag ☐ NS Flush	***DOSE:*** _____mg ***OR*** _____mg/kg (Wt: _____kg ***OR*** _____lbs) ☐ **Loading dose:** Infuse IV at week 0, week 2, and week 6; ***then:*** ☐ **Maintenance dose:** Infuse IV every _____ weeks ☐ Other:	☐ Loading doses ***then:*** ☐ 1 dose ☐ Other:	
☐ RITUXAN ☐ 1000ml NS IV Bag ☐ NS Flush	☐ Infuse 1,000mg IV on day 1 and 15 every 6 months	☐ 2 doses	
☐ SIMPONI 50mg ☐ PEN ☐ PFS	☐ 50mg SQ once a month ☐ Other:	☐ 1 month ☐ 3 months ☐ Other:	
☐ SIMPONI ARIA	***DOSE:*** _____mg ***OR*** _____mg/kg (Wt: _____kg ***OR*** _____lbs) ☐ **Loading dose:** Infuse IV at week 0, week 4; ***then:*** ☐ **Maintenance dose:** Infuse IV every 8 weeks ☐ Other:	☐ Loading doses ***then:*** ☐ 1 month ☐ 3 months ☐ Other:	
☐ STELARA 45mg PFS ☐ STELARA 45mg VIALS ☐ STELARA 90mg PFS	☐ **Loading dose:** Inject _____mg SQ at week 0, week 4, ***then:*** ☐ **Maintenance dose:** Inject _____mg SQ every _____ weeks ☐ Other:	☐ Loading doses ***then:*** ☐ 1 month ☐ 3 months ☐ Other:	
☐ TALTZ 80mg ☐ PEN ☐ PFS	☐ **Loading dose:** Inject 160mg SQ once, ***then:*** ☐ **Maintenance dose:** Inject 80mg SQ every 4 weeks. ☐ Other:	☐ Loading doses ***then:*** ☐ 1 month ☐ 3 months ☐ Other:	
☐ XELJANZ 5mg Tablets ☐ XELJANZ XR 11mg Tablets	☐ 1 tablet by mouth twice daily ☐ 1 tablet by mouth daily ☐ Other:	☐ 1 month ☐ 3 months ☐ Other:	

Ship to: ☐ Physician's Office ☐ Patient ☐ Other address:

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Aetna Specialty Pharmacy refers to Aetna Specialty Pharmacy, LLC, a subsidiary of Aetna Inc., which is a licensed pharmacy that operates through specialty pharmacy prescription fulfillment. This pharmacy is a for-profit entity.