



Patient Referral/Medication Request - Crohn's Disease/Rheumatoid/ Psoriatic Arthritis Therapy

Aetna Specialty Pharmacy®
503 Sunport Lane
Orlando, FL 32809
Phone: 1-866-782-2779 (1-866-782-ASRX)
FAX: 1-866-329-2779 (1-866-FAX-ASRX)

Today's Date: _____ Anticipated Start Date: _____

PATIENT INFORMATION

First Name:		Last Name:	
Address:		City:	State: Zip:
Home Phone:		Work Phone:	Cell Phone:
DOB:	Height:	Weight:	Allergies:
Ship Meds to: <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Doctor's Office			

INSURANCE INFORMATION

Primary Insurance:		Pharmacy Benefit Manager (PBM):	
Policy #:	Group #:	Insured:	Phone:
Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, provide #:	Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, provide #:

Secondary Insurance:

Policy #:	Group #:	Insured:	Phone:
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PHYSICIAN INFORMATION

First Name:		Last Name:		M.D./D.O.	
Address:		City:	State:	Zip:	
Phone:	Fax:	St Lic. #:	NPI #:	DEA #:	UPIN:
Office Contact Name:				Phone:	

DIAGNOSIS:

Primary:	ICD 9:	Secondary:	ICD 9:
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PRESCRIPTION (Please select from below and provide approximate days supply.)

ENBREL # of Refills _____

Enbrel 25mg 4 vials per box qty _____ boxes

Enbrel 50mg 4 pre-fill syringes per box qty _____ boxes

Enbrel 50mg Sure -click 4 per box qty _____ boxes

Directions: _____

REMICADE # of Refills _____

Patient's Current Weight: _____ lbs/kg (required)
Dose per kg _____

One per infusion:

Remicade 100mg vials qty _____ vials

Excel Sodium Chloride 250ml qty _____ bags

Sterile H2O 10ml/vial qty _____ vials

NS Flush 10ml/PFS qty _____ syringes

Epipen® Benadryl® 50mg vial PRN allergic reaction

Directions: _____

METHOTREXATE # of Refills _____

Methotrexate 25mg/ml

Directions: _____

Withdraw and inject _____ mg SQ/ IM _____ every _____

Other Drug: _____ strength _____

Frequency _____ Route _____

of Refills _____

Directions: _____

HUMIRA # of Refills _____

Humira Crohn's Titration Pack given as

4 pens (160mg) SQ x 1 dose as initial dose followed by 2 pens (80mg) on day 15

Then 40mg SQ every other week thereafter

Or

2 pens (80mg) QD x 2 days as initial dose followed by 2 pens (80mg) QD on day 15 SQ

Then 40mg SQ every other week thereafter

Humira 40mg 2 syringes per box qty _____ boxes

Humira 40mg 2 pens per box qty _____ boxes

Directions: _____

ORENCIA # of Refills _____

Patient's Current Weight: _____ lbs/kg (required)

Orencia 250mg vials

BODY WEIGHT OF PATIENT	DOSE	NUMBER OF VIALS*
<input type="checkbox"/> <60 kg	500 mg	2
<input type="checkbox"/> 60 to 100 kg	750 mg	3
<input type="checkbox"/> >100 kg	1 gram	4

*Each vial provides 250 mg of abatacept for administration

100ml Sodium Chloride Injectable 0.9% IV bag

Sterile H2O 10 mL/vial

NS Flush 10mL/PFS qty _____

Epipen® Benadryl® 50mg vial PRN allergic reaction

Directions: _____

KINERET # of Refills _____

Kineret 100mg 28 syringes per box qty _____ boxes

Directions: _____

Prescriber's Signature Required by Law:

Interchange is mandated unless practitioner writes the words "NO SUBSTITUTION" in this space.
Incomplete information may result in therapy delay. Please complete all fields.