**LOVELACE SPECIALTY PHARMACY**

500 Walter St Suite 202B Albuquerque, NM 87102

Ph: (505) 727-4532 Toll Free: (888) 727-4530

Fax: (505) 727-2911

**Patient Information**

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Last Name

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Date of Birth

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City State Zip

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Phone number

**Prescriber Information**

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Prescriber Name

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Prescriber Address

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City State Zip

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Phone Number Fax Number

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NPI # DEA #

**Insurance Information (fax a copy of card)**

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Subscriber Name

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Group #

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ID #

**Prescription**

**Xeljanz (**tofacitinib)

Dispense\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Refills\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Take 5mg tablet by mouth twice daily

Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Otezla** (apremilast)

Dispense\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Refills\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Take 30mg tablet by mouth:

□ once daily for 30 days □ twice daily for 30 days

Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Cimzia** (certolizumab)

□ Inject 400mg sc initially then repeat dose at weeks 2 and 4. (Initial dose)

□ Inject 200mg every other week (maintenance dose)

□ Inject 400mg sc every 4 weeks (maintenance dose)

**Enbrel Pre-filled Syringe** (etanercept)

Dispense\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Refills\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Inject **25MG** sc every week

□ Inject **50MG** sc every week

□ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Enbrel Sureclick** (etanercept)

Dispense\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Refills\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**□** Inject 50mg sc every week

□ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Humira Psoriasis Starter kit**

Dispensed as one kit (4 pre-filled syringes)

□Inject 80mg sc as one single dose day 1 then 40mg at week 1 and every other week thereafter

**Humira Pen** (adalimumab)

Dispense\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Refills \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Inject 40mg sc every **other** week

□ Inject 40mg sc every week

□ Inject 80mg (2 pens) every other week

**Humira Pre-Filled Syringe** (adalimumab)

Dispense\_\_\_\_\_\_ Refills \_\_\_\_

□ Inject 40mg sc every **other** week

□ Inject 40mg sc every week

□ Inject 80mg (2 syringes) every other week

**Kineret** (Anakinra)

Dispense\_\_\_\_\_\_ Refills \_\_\_\_\_\_

□ Inject 100mg sc Daily

□ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Orencia PFS** (Abatacept)

Dispense\_\_\_\_\_ Refills\_\_\_\_\_\_

□ Inject 125mg on day 1 after initial loading dose and every week thereafter.

 **Simponi** (golimumab)

PFS\_\_\_\_\_ PEN\_\_\_\_\_\_\_

Dispense\_\_\_\_\_\_ Refills \_\_\_\_\_\_

□ Inject 50MG sc every month

□ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Methotrexate Injection**

 □ Vials

Dispense\_\_\_\_\_\_ Refills \_\_\_\_\_\_

□ Inject \_\_\_\_\_\_ \_\_IM\_\_SUB-Q\_\_ weekly

 **Methotrexate 2.5mg Tablets**

Dispense\_\_\_\_\_\_ Refills \_\_\_\_\_\_

□ Take \_\_\_\_ Tablets PO once weekly

**Prescriber Signature:**

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**Date:**

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