



Fax the completed form to
(818) 236-2504

Questions? Call (818) 236-2500
Monday to Friday, 10 am to 6 pm

E-prescribing? Send to Foothill Remedy Drugs
6253 Foothill Blvd, Tujunga, CA 91042 · NPI 1134270135

Please send with this form: ☐ Insurance cards, front and back ☐ Recent labs ☐ Clinical notes ☐ Current medication list

1 Patient

Or attach a patient face sheet

Last name _____ First name _____ Date of birth _____

Sex ☐ F ☐ M ☐ X Height _____ Weight _____ ☐ kg ☐ lb Allergies ☐ None known _____

Address _____ City _____ State _____ ZIP _____

Cell phone _____ Other phone _____ Email _____

Preferred language ☐ English ☐ Armenian ☐ Farsi ☐ Russian ☐ Spanish ☐ Other _____

2 Insurance

Or attach copies of the cards, front and back

Primary plan _____ Member ID _____ Group # _____ Phone _____

Secondary plan _____ Member ID _____ Group # _____ Phone _____

3 Prescriber

Prescriber name _____ NPI _____ License # _____

Practice _____ Specialty _____

Address _____ City _____ State _____ ZIP _____

Phone _____ Fax _____ Office contact _____

Contact phone _____ Contact email _____

4 Clinical information

Please attach recent labs and notes

Diagnosis ☐ Rheumatoid arthritis ☐ Psoriatic arthritis ☐ Ankylosing spondylitis ☐ Non-radiographic axial SpA ☐ Juvenile arthritis

☐ Giant cell arteritis ☐ Other _____ ICD-10 code _____

Disease activity score (CDAI, DAS28 or other) _____ Year diagnosed _____

Tried before ☐ Methotrexate ☐ Leflunomide ☐ Sulfasalazine ☐ Hydroxychloroquine ☐ Biologic or JAK _____

Therapy status ☐ New start ☐ Continuing current therapy ☐ Switching from _____

Reason for switching _____

TB test ☐ Negative ☐ Positive Date _____ Hepatitis B screen ☐ Negative ☐ Positive ☐ Not done

Current medications ☐ List attached _____

5 Delivery

Needed by _____ Deliver to ☐ Patient's home ☐ Prescriber's office ☐ Patient will pick up at the pharmacy

Delivery is free within 25 miles of our Tujunga store.

Patient name _____ Date of birth _____

6 Prescription

Check each medication to fill. Directions and quantity can be changed.

☐ **New start: also dispense the loading doses in each checked drug's label**

Medication	Strength	Directions	Quantity	Refills
TNF blockers				
☐ Humira adalimumab	40 mg/0.4 mL pen	Inject 40 mg subcut every other week	2 pens	_____
☐ Adalimumab biosimilar the plan's preferred biosimilar	40 mg pen	Inject 40 mg subcut every other week	2 pens	_____
☐ Enbrel etanercept	50 mg/mL SureClick	Inject 50 mg subcut once weekly	4 pens	_____
☐ Cimzia certolizumab pegol	200 mg/mL syringe	Inject 200 mg subcut every other week	2 syringes	_____
☐ Simponi golimumab	50 mg/0.5 mL SmartJect	Inject 50 mg subcut once a month	1 pen	_____
Other biologics				
☐ Orencia abatacept	125 mg/mL ClickJect	Inject 125 mg subcut once weekly	4 pens	_____
☐ Tyenne or Avtozma tocilizumab biosimilar; weekly if 100 kg or more	162 mg/0.9 mL syringe	Inject 162 mg subcut every other week	2 syringes	_____
☐ Stelara ustekinumab; 90 mg if over 100 kg	45 mg or 90 mg syringe	Inject 45 mg subcut every 12 weeks	1 syringe	_____
☐ Ustekinumab biosimilar plan's preferred; 90 mg if over 100 kg	45 mg or 90 mg syringe	Inject 45 mg subcut every 12 weeks	1 syringe	_____
☐ Tremfya guselkumab	100 mg/mL pen	Inject 100 mg subcut every 8 weeks	1 pen	_____
☐ Skyrizi risankizumab-rzaa	150 mg/mL pen	Inject 150 mg subcut every 12 weeks	1 pen	_____
☐ Bimzelx bimekizumab-bkzx	160 mg/mL pen	Inject 160 mg subcut every 4 weeks	1 pen	_____
Tablets and methotrexate				
☐ Xeljanz tofacitinib	5 mg tablet	Take 1 tablet by mouth twice daily	60 tablets	_____
☐ Xeljanz XR tofacitinib extended-release	11 mg tablet	Take 1 tablet by mouth once daily	30 tablets	_____
☐ Methotrexate injection syringes and needles included	25 mg/mL vial	Inject ____ mg subcut once weekly on ____	1 vial	_____
☐ Methotrexate tablets methotrexate	2.5 mg tablet	Take ____ tablets by mouth once weekly on ____	____ tablets	_____
☐ Folic acid folic acid	1 mg tablet	Take 1 tablet by mouth once daily	30 tablets	_____

Other medication (write in)

☐

☐

7 Prescriber signature

By signing, I confirm that this medication is medically necessary and that the information on this form is accurate to the best of my knowledge.

Prescriber signature _____ Date _____

☐ Do not substitute Prescriber initials _____ California law requires the prescriber to initial this box to prevent substitution.