Genefic
SPECIALTY PHARMACY

To expedite processing, please send the following information with prescription.

- ☐ Referral Form
- ☐ Demographic Sheet
- ☐ Most Recent Clinical Notes
- ☐ List of Tried and Failed Meds (Including other Biologics)
- ☐ Prescription Insurance Card (Front & Back)

Bio-Coordinator or Primary Point of Contact at Clinic:

Name: _____

Email: _____

Direct Phone Line: _____

Cell (optional, but preferred): _____

Genefic Specialty Pharmacy
2577 Mall Road, Suite B
Florence, AL, 35630

Phone: (833) 928-7660
Fax: (833) 928-7661
Website: GeneficRx.com

Faxed prescriptions will only be accepted from a prescriber. Patients must bring an original prescription to the pharmacy, and cannot fax these referral forms to Genefic Specialty Pharmacy.

Ankylosing Spondylitis Enrollment Form

Prescriber:	**NPI:**
Supervising Physician:	**NPI:**
Address:	**Tax ID:**
Phone:	Fax:
Contact:	

PATIENT INFORMATION

Name:	☐ M ☐ F ☐ Trans M ☐ Trans F ☐ Other	DOB: ____/____/_____	SS#: ____-____-_____
Street:	City:	State:	ZIP:
Phone:	Alt. Phone:	☐ English ☐ Spanish ☐ Other: _____	Wt.: _____ Ht.: _____

PRESCRIPTION

Has the patient received a loading dose/starter kit? ☐ **Yes Start Date:** ____/____/_____ ☐ **No** | **Ship to:** ☐ **Patient's Home** ☐ **Doctor's Office** ☐ **Other:** _____

Drug		Directions & Quantity		Refills
Cimzia®	☐ Pre-filled Syringe ☐ Vials	☐ **INITIAL:** Inject 400 mg SQ at weeks 0, 2, & 4 (Quantity: 6) ☐ **MAINTENANCE:** Inject 400 mg SQ every 4 weeks (Quantity: 2) ☐ **MAINTENANCE:** Inject 200 mg SQ every **other** week (Quantity: 2)		
Cosentyx®	☐ Sensoready Pen ☐ Pre-filled Syringe	☐ **INITIAL:** Inject 150 mg SQ at week 0, 1, 2, 3, & 4 (Quantity: 5) ***Dosing intended for Non-Radiographic Axial Spondyloarthritis***	☐ **MAINTENANCE:** Inject 150 mg SQ every 4 weeks (Quantity: 1) ***Dosing intended for Non-Radiographic Axial Spondyloarthritis***	
		☐ **INITIAL:** Inject 300 mg SQ at week 0, 1, 2, 3, & 4 (Quantity: 10)	☐ **MAINTENANCE:** Inject 300 mg SQ every 4 weeks (Quantity: 2)	
Enbrel®	☐ SureClick® Pen ☐ Mini® with AutoTouch® ☐ 50 mg Pre-filled Syringe	☐ Inject 50 mg SQ every week (Quantity: 4)		
Humira® ***Citrate Free***	☐ Pen ☐ Pre-filled Syringe	☐ Inject 40 mg SQ every **other** week (Quantity: 2)		
Rinvoq®	15 mg Tablets	☐ Take 15 mg PO once daily (Quantity: 30)		
Simponi®	☐ SmartJect® Pen ☐ Pre-filled Syringe	☐ Inject 50 mg SQ once a month (Quantity: 1)		
Taltz®	☐ Autoinjector ☐ Pre-filled Syringe	☐ **INITIAL:** Inject 160 mg SQ at week 0 (Quantity: 2) ☐ **MAINTENANCE:** Inject 80 mg SQ every 4 weeks (Quantity: 1) ☐ Inject 80 mg SQ every 4 weeks (Quantity: 1) ***Dosing intended for Non-Radiographic Axial Spondyloarthritis (Nr-axSpA)***		
Xeljanz®	5 mg Tablets	☐ Take 5 mg PO twice daily (Quantity: 60)		
Xeljanz® XR	11 mg Tablets	☐ Take 11 mg PO once daily (Quantity: 30)		

MEDICAL INFORMATION

PLEASE FAX COPY OF PRESCRIPTION/MEDICAL CARD, FRONT AND BACK, AS WELL AS ANY CLINICAL NOTES REGARDING THERAPY

PREVIOUS THERAPIES:	Tried & Failed (Duration):	Not Tolerated:	Contraindication:
☐ Methotrexate	☐ (_____)	☐	_____
☐ Enbrel	☐ (_____)	☐	_____
☐ Humira	☐ (_____)	☐	_____
☐ _____	☐ (_____)	☐	_____
☐ _____	☐ (_____)	☐	_____

☐ M45.9 Ankylosing Spondylitis, Unspecified

☐ M45.____ _____

☐ M45.A0 Non-Radiographic Axial Spondyloarthritis (Nr-axSpA) of unspecified sites in spine

☐ M45.A____ _____

☐ M46.8___ _____

☐ Other: _____

Date of Diagnosis: _____/_____/_____ **Allergies:** _____

Active TB is ruled out: ☐ Yes ☐ No Date: ____/____/_____ Hep B ruled out/treated: ☐ Yes ☐ No Date: ____/____/_____

HLA-B27 Positive: ☐ Yes ☐ No Date: ____/____/_____

Additional Clinical Information:

INJECTION TRAINING

☐ Patient has received pen and injection training ☐ Physician's office to provide injection training ☐ Genefic to coordinate injection training

PRESCRIBER SIGNATURE

To Prescriber: By signing this form and utilizing our services, you are also authorizing Genefic Specialty Pharmacy to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies, and co-pay assistance foundations.

Prescriber: | **Date**: _____/_____/_____

CONFIDENTIALITY NOTICE

IMPORTANT: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, proprietary or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.