



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

Adalimumab Biosimilar Abrilada Amjevita Cyltezo Enrollment Form

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

PATIENT INFORMATION

Name:	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Trans M <input type="checkbox"/> Trans F <input type="checkbox"/> Other	DOB: / /	SS#: - -
Street:	City:	State:	ZIP:
Phone:	Alt. Phone:	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> 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
Abrilada™ <input type="checkbox"/> 40 mg/0.8 mL Pen <input type="checkbox"/> 40 mg/0.8 mL Pre-filled Syringe <input type="checkbox"/> 20 mg/0.4 mL Pre-filled Syringe	INITIAL/LOADING DOSES: ***WEIGHT REQUIRED *** <input type="checkbox"/> PSORIASIS/UEVEITIS: Inject 80 mg on SQ day 1, 40 mg on day 8, then 40 mg every other week (Quantity: 4) <input type="checkbox"/> CROHN'S/UC/HS: Inject 160 mg on SQ on day 1, then 80 mg on day 15 (Quantity: 6) <small>***Intended for ped CD patients ≥ 40kg (88 lbs)***</small> <input type="checkbox"/> PEDIATRIC CROHN'S: Inject 80 mg on SQ on day 1, 40 mg on day 15, then 20 mg every other week starting on day 29 (Quantity: QS) <small>***Intended for weight 17 kg (37 lbs) to < 40 kg (88 lbs)***</small> MAINTENANCE DOSES: <input type="checkbox"/> Inject 40 mg SQ every other week (Quantity: 2) <input type="checkbox"/> Inject 40 mg SQ weekly (Quantity: 4) <input type="checkbox"/> Inject 80 mg SQ every other week (Quantity: 4) <input type="checkbox"/> Inject 20 mg SQ every other week (Quantity: 2) <small>***Intended for JIA patients 15 kg (33 lbs) to <30 kg (66 lbs) OR Crohn's disease patients 17kg (37 lbs) to less than 40 kg (88 lbs)***</small>	
Amjevita™ <input type="checkbox"/> 40 mg/0.8 mL Sureclick® Autoinjector <input type="checkbox"/> Pre-filled Syringe <input type="checkbox"/> 40 mg/0.8 mL <input type="checkbox"/> 20 mg/0.4 mL <input type="checkbox"/> 10mg/0.2 mL	INITIAL/LOADING DOSES: ***WEIGHT REQUIRED *** <input type="checkbox"/> PSORIASIS/UEVEITIS: Inject 80 mg on SQ day 1, 40 mg on day 8, then 40 mg every other week (Quantity: 4) <input type="checkbox"/> CROHN'S/UC/HS: Inject 160 mg on SQ on day 1, then 80 mg on day 15 (Quantity: 6) <small>***Intended for ped CD patients ≥ 40kg (88 lbs)***</small> <input type="checkbox"/> PEDIATRIC CROHN'S: Inject 80 mg on SQ on day 1, then 40 mg on day 15 (Quantity: 3) <small>***Intended for weight 17 kg (37 lbs) to < 40 kg (88 lbs)***</small> MAINTENANCE DOSES: <input type="checkbox"/> Inject 40 mg SQ every other week (Quantity: 2) <input type="checkbox"/> Inject 40 mg SQ weekly (Quantity: 4) <input type="checkbox"/> Inject 80 mg SQ every other week (Quantity: 4) <input type="checkbox"/> Inject 10 mg SQ every other week (Quantity: 2) <small>***Intended for JIA patients 10 kg (22 lbs) to <15 kg (33 lbs)***</small> <input type="checkbox"/> Inject 20 mg SQ every other week (Quantity: 2) <small>***Intended for JIA patients 15 kg (33 lbs) to <30 kg (66 lbs) OR Crohn's disease patients 17kg (37 lbs) to less than 40 kg (88 lbs)***</small>	
Cyltezo® <input type="checkbox"/> Psoriasis/Uveitis Starter Package <input type="checkbox"/> Crohn's/UC/HS Starter Package <input type="checkbox"/> 40 mg/0.8 mL Pen <input type="checkbox"/> Pre-filled Syringe <input type="checkbox"/> 40 mg/0.8 mL <input type="checkbox"/> 20 mg/0.4 mL <input type="checkbox"/> 10mg/0.2 mL	INITIAL/LOADING DOSES: ***WEIGHT REQUIRED *** <input type="checkbox"/> PSORIASIS/UEVEITIS: Inject 80 mg on SQ day 1, 40 mg on day 8, then 40 mg every other week (Quantity: 4) <input type="checkbox"/> CROHN'S/UC/HS: Inject 160 mg on SQ on day 1, then 80 mg on day 15 (Quantity: 6) <small>***Intended for ped CD patients ≥ 40kg (88 lbs)***</small> <input type="checkbox"/> PEDIATRIC CROHN'S: Inject 80 mg on SQ on day 1, then 40 mg on day 15 (Quantity: 3) <small>***Intended for weight 17 kg (37 lbs) to < 40 kg (88 lbs)***</small> MAINTENANCE DOSES: <input type="checkbox"/> Inject 40 mg SQ every other week (Quantity: 2) <input type="checkbox"/> Inject 40 mg SQ weekly (Quantity: 4) <input type="checkbox"/> Inject 80 mg SQ every other week (Quantity: 4) <input type="checkbox"/> Inject 10 mg SQ every other week (Quantity: 2) <small>***Intended for JIA patients 10 kg (22 lbs) to <15 kg (33 lbs)***</small> <input type="checkbox"/> Inject 20 mg SQ every other week (Quantity: 2) <small>***Intended for JIA patients 15 kg (33 lbs) to <30 kg (66 lbs) OR Crohn's disease patients 17kg (37 lbs) to less than 40 kg (88 lbs)***</small>	

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:
<input type="checkbox"/> Methotrexate	<input type="checkbox"/> (_____)	<input type="checkbox"/>	_____
<input type="checkbox"/> Enbrel	<input type="checkbox"/> (_____)	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/> (_____)	<input type="checkbox"/>	_____
<input type="checkbox"/> H20.9 Iridocyclitis (Uveitis), unspecified	<input type="checkbox"/> K50.90 Crohn's disease unspecified, without complications	<input type="checkbox"/> K51.90 Ulcerative Colitis unspecified, without complications	
<input type="checkbox"/> L40.0 Psoriasis Vulgaris (Plaque Psoriasis)	<input type="checkbox"/> L40.50 Arthropathic Psoriasis, unspecified (Psoriatic Arthritis)	<input type="checkbox"/> L73.2 Hidradenitis suppurativa	
<input type="checkbox"/> M06.9 Rheumatoid Arthritis, unspecified	<input type="checkbox"/> M08.09 Unspecified juvenile RA, multiple sites (pcJIA)	<input type="checkbox"/> M45.9 Ankylosing Spondylitis, unspecified	
<input type="checkbox"/> Other: _____			
Date of Diagnosis: / /	Allergies: _____		
Active TB is ruled out: <input type="checkbox"/> Yes <input type="checkbox"/> No	Date: / /	Hep B ruled out/treated: <input type="checkbox"/> Yes <input type="checkbox"/> 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 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.