CareFirst BlueChoice

CareFirst BlueCross BlueShield

CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. Prescription Form

Please fax form to **1.877.800.4791** with a copy of member insurance ID card. For questions, please call **1.888.OncoSRx (662.6779).**

Patient Information

Last Name: First Name:

Home Phone Number: ( ) Work Phone Number: ( )

Home Address: City: State: Zip:

Date of Birth: Allergies: ❑ NKA ❑ Other (List):

Insurance ID #: Group #:

Physician Information

MD Name:

MD DEA #: NPI #:

Address: City: State: Zip:

Office Contact Name: Phone Number: ( ) Fax Number: ( )

Primary Diagnosis

Primary ICD9 (Code): Primary Diagnosis (In Words):

Select the medication and diagnosis:

	Moderate to Severe Rheumatoid Arthritis	Psoriatic Arthritis	Ankylosing Spondylitis	Moderate to Severe Juvenile Idiopathic Arthritis
Cimzia	❑	n/a	n/a	n/a
Enbrel	❑	❑	❑	❑
Humira	❑	❑	❑	❑
Kineret	❑	n/a	n/a	n/a
Simponi	❑	❑	❑	n/a
Orencia SQ	❑	n/a	n/a	n/a

Clinical Information

1. Is the patient naive to therapy or continuing therapy? ❑ Naive ❑ Continuing If continuing, how long has the patient been on this medication?_______________
2. Has a dermatologist/rheumatologist recommended or requested therapy? ❑ Yes ❑ No
3. Has the patient failed or had an inadequate response to the trial of at least one or more disease-modifying antirheumatic drugs (DMARDS)? (eg, methotrexate, Imuran, Ridaura, Plaquenil, Cuprimine, Azulfidine, Arava) ❑ Yes ❑ No
4. Is the patient receiving a tumor necrosis factor (TNF)-blocking agent? ❑ Yes ❑ No
5. Will the TNF-blocking agent be discontinued? ❑ Yes ❑ No
6. Is the patient currently taking methotrexate? ❑ Yes ❑ No
7. Has the patient failed or had an inadequate response to a 3-month trial of Humira? ❑ Yes ❑ No
8. Has the patient failed or had an inadequate response to a 3-month trial of Enbrel? ❑ Yes ❑ No

Prescription Information

Drug Name: Strength: Quantity:

SIG: Refills:

❑ 30 Day ❑ 90 Day

Physician Signature Required

Information on this form is accurate as of this date: ____ /____ /____ **MD Signature:**

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