**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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First 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**

** Humira Pen** (adalimumab)

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

□ Inject 40mg sc every **other** week

□ Inject 40mg sc every week

□ Inject 80mg (2 pens) every other week

□ Other

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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

□Other

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Humira Crohn’s Starter Kit** (adalimumab)

Dispensed as one kit (6 injections)

Inject 4 pens (160mg) on day 1, inject 2 pens (80mg) on day 15, then 1 pen (40mg) every other week thereafter

 **Cimzia** (certolizumab)

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

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

□ Inject 200mg sc every other week (maintenance dose)

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

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**Methotrexate Injection**

 □ Vials

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

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

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

**Methotrexate Tablets**

□ 2.5mg Tablets

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

□ Take \_\_\_\_ tablets by mouth once weekly

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Other** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

□ Directions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Other** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Directions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Other** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

□ Directions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Other**

Ship to patient’s home

Ship to provider’s office

 provider will counsel the patient

**Provider Signature:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_