SYNERGEN Rx
www.synergenrx.com

Rheumatology A-I

Phone 404-585-7517
Fax: 404-900-9209
NPI: 1811550528

Patient Information (Please attach insurance card)

Name:	☐ M ☐ F	DOB: ___/___/___	
Street:	City	State:	Zip:
Phone:	Alt Phone:	Allergies:	

Clinical Information (Please attach all pertinent clinicals and lab results)

Diagnosis: ☐ Rheumatoid Arthritis ☐ Psoriatic Arthritis ☐ Ankylosing Spondylitis
☐ Juvenile Rheumatoid Arthritis ☐ Other: _____ Number of Joints affected _____
Weight: _____ TB Test ☐ Y ☐ N Result: _____
Previous Tried/Failed Medications: Duration:
_____ _____
_____ _____
Active Infections ☐ Y ☐ N
Hep B Negative ☐ Y ☐ N

Prescription

Injection Training ☐ Prescribers Office ☐ Specialty Pharmacy

Drug Therapy	*Dosing*	*Directions*	*Quantity*	*Refills*
☐ Actemra ☐ PFS ☐ PEN ☐ Vial	☐ 162 mg	Inject 162 mg Sub-Q ☐ ONCE a week ☐ every OTHER week		
	☐ Vial	Infuse _____mg every 4 weeks		
☐ Benlysta ☐ PFS ☐ PEN ☐ Vial	☐ 200mg	Inject 200 mg under the skin once weekly		
	☐ 120mg/5mL ☐ 400mg/20mL	☐ Infuse _____mg at weeks 0, 2 and 4 weeks there after ☐ Infuse _____mg every 4 weeks		
☐ Cimzia	☐ Starter Kit	Inject 400 mg (Two 200mg PFS) under the skin on weeks 0, 2, & 4	6 Syringes	
	☐ Maintenance	☐ Inject 200 mg under the skin every 2 weeks ☐ Inject 400 mg (Two 200mg PFS) under the skin every 4 weeks		
☐ Cosentyx ☐ Pen ☐ PFS	☐ Induction	Inject 150 mg under the skin weeks 0,1,2,3, and 4	10 Pens	
	☐ Maintenance	Inject 150 mg under the skin every 4 weeks		
☐ Enbrel ☐ Mini Cartridge ☐ 25mg PFS ☐ 50mg PFS ☐ PEN ☐ Vial	☐ Injection	Inject 50mg once weekly		
	☐ Vial	Infuse _____ mg weekly, with a maximum of 50mg per week		
☐ Humira Citrate Free ☐ Pen ☐ PFS	☐ 20mg (<66 lbs) ☐ 40mg	☐ Inject every OTHER week ☐ Inject ONCE weekly		
☐ Inflectra ☐ Renflexis ☐ Remicade	Induction	Infuse _____mg at weeks 0, 2 and 6, then every 8 weeks there after		
	Maintenance	Infuse _____ mg every _____weeks		

Prescriber information

Deliver To: ☐ Patient ☐ Office

Prescriber:			Supervising Physician:
Contact Name:			Preferred method of contact: ☐ Phone ☐ Fax ☐ Email
Phone:	Ext:	Fax:	Email:
Street:	City:	State:	Zip:
Signature:	Date:	NPI	

*By signing this form I authorize Synergen RX LLC and its employees to act as authorized agents on behalf of my office to obtain prior authorization through my patients insurance plan and to facilititate and enroll patients into patient assistance programs with manufacturers and other foundations.

SYNERGEN Rx
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Rheumatology J-R

Phone 404-585-7517
Fax: 404-900-9209
NPI: 1811550528

Patient Information (Please attach insurance card)

Name:	☐ M ☐ F	DOB: ___/___/___	
Street:	City	State:	Zip:
Phone:	Alt Phone:	Allergies:	

Clinical Information (Please attach all pertinent clinicals and lab results)

Diagnosis: ☐ Rheumatoid Arthritis ☐ Psoriatic Arthritis ☐ Ankylosing Spondylitis ☐ Juvenile Rheumatoid Arthritis

☐ Other:_____ Number of Joints affected _____

Weight: _____ TB Test ☐ Y ☐ N Result: _____

Previous Tried/Failed Medications: Duration:

_____ _____

_____ _____

Active Infections ☐ Y ☐ N

Hep B Negative ☐ Y ☐ N

Prescription

Injection Training ■ Prescribers Office ■ Specialty Pharmacy

Drug Therapy	*Dosing*	*Directions*	*Quantity*	*Refills*
☐ Kevzara ☐ PFS ☐ PEN	☐ 150mg ☐ 200mg	Inject subcutaneously every 2 weeks		
☐ Olumiant	2mg	Take 1 tablet by mouth daily		
☐ Orencia ☐ PFS ☐ Clickjet	125mg	Inject 125 mg under the skin every week		
☐ Otezla	☐ Titration Pack	☐ Take as directed per titration package ☐ Please check if patient has already received 14-day titration pack from MD office	55	
	☐ 30 mg tablet maintenance	☐ Take 1 tablet twice daily ☐ Take 1 tablet daily (For renal impairment)		
☐ Inflectra ☐ Renflexis ☐ Remicade	☐ Induction	Infuse _____ mg at weeks 0, 2 and 6, then every 8 weeks there after		
	☐ Maintenance	Infuse _____ mg every _____ weeks		
☐ Rinvoq	15mg	Take 1 tablet by mouth once daily		
☐ Rituxan	☐ 100mg/10mL ☐ 500mg/50mL	Infuse two doses of 1000mg separated by 2 weeks every _____ weeks		

Prescriber information

Deliver To: ■ Patient ■ Office

Prescriber:			Supervising Physician:
Contact Name:			Preferred method of contact: ☐ Phone ☐ Fax ☐ Email
Phone:	Ext:	Fax:	Email:
Street:	City:	State:	Zip:
Signature:	Date:	NPI	

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SYNERGEN Rx
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Rheumatology S-Z

Phone 404-585-7517
Fax: 404-900-9209
NPI: 1811550528

Patient Information (Please attach insurance card)

Name:	☐ M ☐ F	DOB: ___/___/___	
Street:	City	State:	Zip:
Phone:	Alt Phone:	Allergies:	

Clinical Information (Please attach all pertinent clinicals and lab results)

Diagnosis: ☐ Rheumatoid Arthritis ☐ Psoriatic Arthritis ☐ Ankylosing Spondylitis ☐ Juvenile Rheumatoid Arthritis
☐ Uveitis: _____ ☐ Other: _____ Number of Joints affected _____

Weight: _____ TB Test ☐ Y ☐ N Result: _____

Previous Tried/Failed Medications: Duration:

_____ _____

_____ _____

Active Infections ☐ Y ☐ N

Hep B Negative ☐ Y ☐ N

Prescription

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Drug Therapy	*Dosing*	*Directions*	*Quantity*	*Refills*
☐ Simponi ☐ PFS ☐ PEN	☐ 50mg	Inject 50mg Sub-Q one a month		
☐ Simponi ARIA	☐ 50mg/4mL vial	Infuse 2mg/kg over 30 minutes at weeks 0 and 4 then every 8 weeks		
☐ Stelara PFS ☐ 45 mg ☐ 90 mg	☐ Induction	Inject 1 syringe under the skin at weeks 0 and week 4	2	
	☐ Maintenance	Inject 1 syringe every 12 weeks		
☐ Taltz 80 mg ☐ Pen ☐ PFS	☐ Induction *(Psoriatic Arthritis only)*	Inject 160mg at week 0, then 80mg every 4 weeks	3	
	☐ Induction *(Coexistant Plaque Psoriasis)*	Inject 160 mg under the skin week 0 then 80 mg every 2 weeks until week 12	8	
	☐ Maintenance	Inject 80 mg under the skin every 4 weeks		
☐ Xeljanz	☐ 5 mg	☐ Take 1 tablet by mouth twice daily ☐ Take 1 tablet once daily (For renally or hepatically impaired)		
☐ Xeljanz XR	☐ 11 mg	Take 1 tablet by mouth daily		

Prescriber information

Deliver To: ■ Patient ■ Office

Prescriber:		Supervising Physician:	
Contact Name:		Preferred method of contact: ☐ Phone ☐ Fax ☐ Email	
Phone:	Ext: Fax:	Email:	
Street:	City:	State:	Zip:
Signature:	Date:	NPI	

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