BARNES HEALTHCARE SERVICES

Humira and Biosimilars Order Form

Please fax all pages of completed form to our Intake team at 888.276.7948
Contact our Intake team 800.422.5059 ext.1480

1 Patient Information — Please provide copies of front and back of all medical and prescription insurance cards.

☐ New patient ☐ Current patient

Patient's first name _____ **Last name** _____ **MI** _____
Preferred patient first name _____ **Preferred patient last name** _____
Sex at birth: ☐ Male ☐ Female **Gender identity** _____ **Pronouns** _____
Last 4 of SSN _____ **Date of birth** _____/_____/_____
Street address _____ **Apt #** _____
City _____ **State** _____ **Zip** _____
Home phone _____ **Cell phone** _____ **Email address** _____
Parent/guardian (if applicable)
Home phone _____ **Cell phone** _____ **Email address** _____
Alternate caregiver/contact
Home phone _____ **Cell phone** _____ **Email address** _____

☐ OK to leave message with alternate caregiver/contact

Patient's primary language: ☐ English ☐ Other **If other, please specify** _____

Provider will read the following statement to patient: By providing the phone number(s) and email address above, you consent to receiving automated/artificial voice calls, emails and/or text messages from Barnes Healthcare Services about your prescription(s), account, and health care. Standard data rates apply. Message frequency varies.

2 Prescriber Information — All fields must be completed to expedite prescription fulfillment.

Date _____ **Time** _____ **Date medication needed** _____/_____/_____
Office/clinic/institution name
Prescriber's first name _____ **Last name** _____
Prescriber's title _____ **If NP or PA, under direction of Dr.** _____
Office phone _____ **Fax** _____ **NPI #** _____ **License #** _____
Office contact and title _____ **Office contact email** _____
Office street address _____ **Suite #** _____
City _____ **State** _____ **Zip** _____
Infusion location: ☐ Patient's home ☐ Prescriber's office ☐ Infusion site

If infusion site, complete information below:

Infusion site name _____ **Clinic/hospital affiliation** _____
Site street address _____ **Suite #** _____
City _____ **State** _____ **Zip** _____
Infusion site contact _____ **Phone** _____ **Fax**
Email _____

Note: Check the appropriate shipment options in Section 4: Prescribing Information.

3 Clinical Information

Primary ICD-10 code (REQUIRED):_____

Has the patient been treated previously for this condition? ☐ Yes ☐ No

Is patient currently on therapy? ☐ Yes ☐ No

Please list all therapies tried/failed: _____

Patient wt _____ **Date wt obtained:** _____/_____/_____

☐ NKDA **Known drug allergies** _____

Concurrent meds: _____

4 Prescribing Information

Patient weight is requested/required for pediatric patients: _____ *kg*

Medication	Strength / Formulation	Directions	Quantity / Refills
adalimumab-aacf Citrate Free (pediatric weight _____ kg)			
adalimumab-aacf (Citrate Free)	40mg/0.8mL PEN	For Adults and Children ≥6 yrs weighing ≥40kg (88 lbs): Loading dose: ☐ Inject 160mg on day 1 — OR — ☐ Inject 80mg on day 1 and day 2 followed by 80mg SC 2 weeks later (day 15), then maintenance dose starting on day 29	QS for 1-month loading dose No Refills
adalimumab-aacf (Citrate Free)	40mg/0.8mL PEN	For Adults and Children ≥6 yrs weighing ≥40kg: Maintenance dose: Inject 40mg subcutaneously every other week	☐ 1-month supply ☐ 3-month supply ☐ Refill QS 1 year unless otherwise noted ☐ Other _____
Amjevita™ (adalimumab-atto) — Citrate Free — ADULT			
Amjevita™ (ADULT)	☐ 40mg/0.4mL prefilled syringe (PFS) ☐ 40mg/0.4mL SureClick Autoinjector	Loading dose: ☐ Inject 160mg on day 1 — OR — ☐ Inject 80mg on day 1 and day 2 followed by 80mg SC 2 weeks later (day 15), then maintenance dose starting on day 29	QS for 1-month loading dose No Refills
Amjevita™ (ADULT)	☐ 40mg/0.4mL PFS ☐ 40mg/0.4mL SureClick Autoinjector	Maintenance dose: Inject 40mg subcutaneously every other week	☐ 1-month supply ☐ 3-month supply ☐ Refill QS 1 year unless otherwise noted ☐ Other _____

Medication	Strength / Formulation	Directions	Quantity / Refills
Amjevita™ (adalimumab-atto) — Citrate Free — PEDIATRIC (weight _____ kg)			
Amjevita™ (PEDIATRIC)	☐ 40mg/0.4mL PFS ☐ 40mg/0.4mL SureClick Autoinjector	Loading dose: For 17kg to <40kg: ☐ Inject 80mg SC on day 1, then 40mg on day 15, then maintenance on day 29 For ≥40kg: ☐ Inject 160mg day 1 — OR — ☐ Inject 80mg each day 1 and day 2 followed by 80mg SC on day 15, then maintenance on day 29	QS for 1-month loading dose No Refills
Amjevita™ (PEDIATRIC)	☐ 20mg/0.2mL PFS ☐ 40mg/0.4mL PFS ☐ 40mg/0.4mL SureClick Autoinjector	Maintenance dose: For 17kg to <40kg: Inject 20mg SC every other week For ≥40kg: Inject 40mg SC every other week	☐ 1-month supply ☐ 3-month supply ☐ Refill QS 1 year unless otherwise noted ☐ Other _____
Cyltezo® (adalimumab-adbm) — Citrate Free — ADULT			
Cyltezo® (ADULT)	☐ 40mg/0.8mL PEN ☐ 40mg/0.8mL PFS	Loading dose: ☐ Inject 160mg on day 1 — OR — ☐ Inject 80mg on day 1 and day 2 followed by 80mg SC 2 weeks later (day 15), then maintenance on day 29	QS for 1-month loading dose No Refills
Cyltezo® (ADULT)	☐ 40mg/0.8mL PEN ☐ 40mg/0.8mL PFS	Maintenance dose: Inject 40mg subcutaneously every other week	☐ 1-month supply ☐ 3-month supply ☐ Refill QS 1 year unless otherwise noted ☐ Other _____
Cyltezo® (adalimumab-adbm) — Citrate Free — PEDIATRIC (weight _____ kg)			
Cyltezo® (PEDIATRIC)	☐ 40mg/0.8mL PEN ☐ 40mg/0.8mL PFS	Loading dose: For 17kg to <40kg: ☐ Inject 80mg SC on day 1, then 40mg on day 15, then maintenance on day 29 For ≥40kg: ☐ Inject 160mg day 1 — OR — ☐ Inject 80mg on day 1 and day 2 followed by 80mg SC on day 15, then maintenance on day 29	1 starter kit -OR- QS for 1-month loading dose No Refills
Cyltezo® (PEDIATRIC)	☐ 20mg/0.4mL PFS ☐ 40mg/0.8mL PEN ☐ 40mg/0.8mL PFS	Maintenance dose: For 17kg to <40kg: Inject 20mg SC every other week	☐ 1-month supply ☐ 3-month supply

Medication	Strength / Formulation	Directions	Quantity / Refills
		For ≥40kg: Inject 40mg SC every other week	☐ Refill QS 1 year unless otherwise noted ☐ Other _____
adalimumab-adbm — Citrate Free — ADULT			
adalimumab-adbm (ADULT)	☐ 40mg/0.8mL PEN ☐ 40mg/0.8mL PFS	Loading dose: ☐ Inject 160mg on day 1 — OR — ☐ Inject 80mg on day 1 and day 2 followed by 80mg SC on day 15, then maintenance on day 29	QS for 1-month loading dose No Refills
adalimumab-adbm (ADULT)	☐ 40mg/0.8mL PEN ☐ 40mg/0.8mL PFS	Maintenance dose: Inject 40mg subcutaneously every other week	☐ 1-month supply ☐ 3-month supply ☐ Refill QS 1 year unless otherwise noted ☐ Other _____
Hadlima™ (adalimumab-bwwd) — Citrate Free — ADULT			
Hadlima™ (ADULT)	☐ 40mg/0.8mL PFS ☐ 40mg/0.4mL PFS ☐ 40mg/0.8mL PushTouch Autoinjector ☐ 40mg/0.4mL PushTouch Autoinjector	Loading dose: ☐ Inject 160mg on day 1 — OR — ☐ Inject 80mg on day 1 and day 2 followed by 80mg SC on day 15, then maintenance on day 29	QS for 1-month loading dose No Refills
Hadlima™ (ADULT)	☐ 40mg/0.8mL PFS ☐ 40mg/0.4mL PFS ☐ 40mg/0.8mL PushTouch Autoinjector ☐ 40mg/0.4mL PushTouch Autoinjector	Maintenance dose: Inject 40mg subcutaneously every other week	☐ 1-month supply ☐ 3-month supply ☐ Refill QS 1 year unless otherwise noted ☐ Other _____
Humira® (adalimumab) — ADULT			
Humira® (ADULT)	Starter: ☐ 80mg/0.8mL prefilled PEN Starter Package (3 PENS) ☐ 40mg/0.4mL PFS for starter dose	Loading dose: ☐ 160mg injected day 1 — OR — ☐ 80mg injected each day 1 and day 2 followed by 80mg SC on day 15, then maintenance on day 29	1 starter kit -OR- QS for 1-month loading dose No Refills
Humira® (ADULT)	Maintenance: ☐ 40mg/0.4mL citrate free PEN ☐ 40mg/0.4mL citrate free PFS ☐ 40mg/0.8mL PEN	Maintenance dose: Inject 40mg subcutaneously every other week	☐ 1-month supply ☐ 3-month supply ☐ Refill QS 1 year unless otherwise noted ☐ Other _____

Medication	Strength / Formulation	Directions	Quantity / Refills
	☐ 40mg/0.8mL PFS		
Humira® (adalimumab) — PEDIATRIC (weight _____ kg)			
Humira® (PEDIATRIC)	Starter: ☐ 40mg/0.4mL PFS for starter dose	Loading dose: ☐ 160mg injected day 1 — OR — ☐ 80mg injected each day 1 and day 2 followed by 80mg SC on day 15, then maintenance on day 29	1 starter kit -OR- QS for 1-month loading dose No Refills
Humira® (PEDIATRIC)	☐ 40mg/0.4mL PFS for starter dose	Loading dose: 80mg subcutaneously on day 1, then 40mg on day 15, then maintenance on day 29.	
Humira® (PEDIATRIC)	Maintenance: ☐ 40mg/0.4mL citrate free PEN ☐ 40mg/0.4mL citrate free PFS ☐ 40mg/0.8mL PEN ☐ 40mg/0.8mL PFS ☐ 80mg/0.8mL citrate free PEN ☐ 20mg/0.2mL PFS	Maintenance dose: ☐ Inject 40mg subcutaneously every other week ☐ Inject 20mg subcutaneously every other week	☐ 1-month supply ☐ 3-month supply ☐ Refill QS 1 year unless otherwise noted ☐ Other _____
Hyrimoz® (adalimumab-adaz) — Citrate Free — ADULT			
Hyrimoz® (ADULT)	80mg/0.8mL PEN Starter Pack (3 PENS)	Loading dose: ☐ Inject 160mg on day 1 — OR — ☐ Inject 80mg on day 1 and day 2 followed by 80mg SC on day 15, then maintenance on day 29	QS for 1-month loading dose No Refills
Hyrimoz® (ADULT)	☐ 40mg/0.4mL PEN ☐ 40mg/0.4mL PFS	Maintenance dose: Inject 40mg subcutaneously every other week	☐ 1-month supply ☐ 3-month supply ☐ Refill QS 1 year unless otherwise noted ☐ Other _____
adalimumab-adaz — Citrate Free — ADULT			
adalimumab-adaz (ADULT)	☐ 40mg/0.4mL PEN ☐ 40mg/0.4mL PFS ☐ 80mg/0.8mL PEN	Loading dose: ☐ Inject 160mg on day 1 — OR — ☐ Inject 80mg on day 1 and day 2 followed by 80mg SC on day 15, then maintenance on day 29	QS for 1-month loading dose No Refills
adalimumab-adaz (ADULT)	20mg/0.2mL PFS	Maintenance dose: Inject 40mg subcutaneously every other week	☐ 1-month supply

Medication	Strength / Formulation	Directions	Quantity / Refills
			☐ 3-month supply ☐ Refill QS 1 year unless otherwise noted ☐ Other _____
Hyrimoz® (adalimumab-adaz) — Citrate Free — PEDIATRIC (weight _____ kg)			
Hyrimoz® (PEDIATRIC)	☐ 80mg/0.8mL and 40mg/0.4mL PFS Pediatric Crohn's Starter Pack (2 PFS) ☐ 80mg/0.8mL PFS Pediatric Crohn's Starter Pack (3 PFS)	Loading dose: For 17kg to <40kg: ☐ Inject 80mg SC on day 1, then 40mg on day 15, then maintenance on day 29 For ≥40kg: ☐ Inject 160mg on day 1 — OR — ☐ Inject 80mg each day 1 and day 2 followed by 80mg SC on day 15, then maintenance on day 29	QS for 1-month loading dose No Refills
Hyrimoz® (PEDIATRIC)	☐ 20mg/0.2mL PFS ☐ 40mg/0.4mL PFS ☐ 40mg/0.4mL PEN	Maintenance dose: For 17kg to <40kg: Inject 20mg SC every other week For ≥40kg: Inject 40mg SC every other week	☐ 1-month supply ☐ 3-month supply ☐ Refill QS 1 year unless otherwise noted ☐ Other _____
adalimumab-adaz — Citrate Free — PEDIATRIC (weight _____ kg)			
adalimumab-adaz (PEDIATRIC)	☐ 40mg/0.4mL PFS ☐ 40mg/0.4mL PEN ☐ 80mg/0.8mL PEN	Loading dose: For 17kg to <40kg: ☐ Inject 80mg SC on day 1, then 40mg on day 15, then maintenance on day 29 For ≥40kg: ☐ Inject 160mg on day 1 — OR — ☐ Inject 80mg each day 1 and day 2 followed by 80mg SC on day 15, then maintenance on day 29	QS for 1-month loading dose No Refills
adalimumab-adaz (PEDIATRIC)	20mg/0.2mL PFS	Maintenance dose: For 17kg to <40kg: Inject 20mg SC every other week For ≥40kg: Inject 40mg SC every other week	☐ 1-month supply ☐ 3-month supply ☐ Refill QS 1 year unless otherwise noted ☐ Other _____
Simlandi® (adalimumab-ryvk) — Citrate Free			
Simlandi®	☐ 40mg/0.4mL PFS ☐ 40mg/0.4mL PEN	Loading dose: ☐ Inject 160mg on day 1 — OR —	QS for 1-month loading dose No Refills

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Medication	Strength / Formulation	Directions	Quantity / Refills
		☐ Inject 80mg on day 1 and day 2 followed by 80mg SC on day 15, then maintenance on day 29	
Simlandi®	☐ 40mg/0.4mL PFS ☐ 40mg/0.4mL PEN	Maintenance dose: Inject 40mg subcutaneously every other week	☐ 1-month supply ☐ 3-month supply ☐ Refill QS 1 year unless otherwise noted ☐ Other _____
Other			

Dispense needles, syringes, ancillary supplies and home medical equipment necessary to administer medication.
(S9359, S9379)

Prescriber's signature required (sign below) (Physician attests this is his/her legal signature. NO STAMPS)

SIGN HERE	

Date _____ ☐ Dispense as written Date _____ ☐ Substitution allowed

The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.