Dose Modification Request Form

CORE CONNECTIONS
Coverage, Resources and Education

Patient ID: _____
(Internal Use Only)

Patient Information (Required)*

*First Name:_____ MI: _____ *Last Name:_____ Sex: ❑M ❑F

Email:_____ Last 4 SSN:_____ *DOB:_____

*Mobile Phone:_____ Alt. Phone:_____ *Preferred : ❑Mobile ❑ Alt. Phone ❑ Text ❑ Email

Address: _____ City:_____ State:_____ Zip: _____

*Allergies:_____ *Other Medications:_____

❑ M06.9 Rheumatoid arthritis, unspecified ❑ M 08.00 Unspecified JRA ❑ L40.9 Psoriasis, unspecified

Other Diagnosis Code: _____ ❑ Medication List Attached *Prior Oral Methotrexate?_____

Prescriber Information

*Physician Name:_____ *NPI #: _____ State License #: _____

Practice Name: _____

*Office Phone: _____ Alt. Phone:_____ Fax:_____ Email:_____

Preferred Communication: ❑Office ❑ Alt. Phone ❑ Fax ❑ Email Best Time to Contact: ❑ Morning ❑ Afternoon ❑ Evening

Address: _____

City: _____ State:_____ Zip: _____

Office Contact Name:_____ Contact Phone: _____

Dose Modification Detail

Dose Modification Notes:

Prescribing Information: NY Prescribers – Please Submit Prescription on an Original NY State Prescription Blank

Medication	Strength	Directions	Quantity/Refills
Rasuvo (Methotrexate Inj. SC)	❑7.5mg ❑10 mg ❑12.5mg ❑15 mg ❑17.5 mg ❑20 mg ❑22.5 mg ❑25 mg ❑30 mg	Inject every week as directed ❑ Rasuvo is shipped directly to the patient. Check here to have the product shipped to the Provider's office.	_____Qty No Refills **Maximum** of **2** atuo-injectors per order, **4** auto-injectors per lifetime.

I certify that this therapy is medically necessary and this information is accurate to the best of my knowledge. I certify that I am the physician that has prescribed Rasuvo® to the previously identified patient. I authorize PharmaCord® on behalf of my patient to facilitate processes to assist the patient in obtaining Rasuvo® as indicated on this prescription. I understand that this medication is being provided free to the named patient by Medac Pharma and agree that no insurer or any government healthcare program may be billed for the cost of this medication.

Physician Signature:_____ Date: _____

Original Signature of prescriber ❑ **Dispense as Written** **Invalid without date**

Eligibility Restrictions: Offer only valid for patients with commercial prescription insurance. Offer not valid for prescriptions reimbursed under any federal or state healthcare program, including Medicare, Medicaid, or any state medical assistance programs. Offer void where prohibited by law, taxed, or restricted.

Fax a completed form to (800) 481-3325
PharmaCord Pharmacy NABP: 1836191 NPI: 1699202838

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