Rheumatology Enrollment Form

PATIENT INFORMATION

Deliver Here ☐

Complete the following or include demographic sheet

Patient Name: _____

Address: _____

City, State, Zip: _____

Male ☐ Female ☐ DOB: _____

Primary Phone: _____ Last 4 of SS: _____

Allergies: _____

PRESCRIBER INFORMATION

Deliver Here ☐

Provider Name: _____

State License#: _____ NPI#: _____

DEA #: _____

Address: _____

City, State Zip: _____

Phone: _____ Fax: _____

Contact Person: _____ Phone: _____

INSURANCE INFORMATION: PLEASE FAX COPY OF INSURANCE CARD (FRONT & BACK)

Primary Diagnogsis: _____

Patient tried and failed to tolerate or respond to at least a three-month trial of MTX? ☐Yes ☐No

Hx of other DMARDs: _____

Current Methotrexate: ☐Yes ☐No

ICD-10 Code: ☐ M06.9 Rheumatoid arthritis, unspecified ☐ M05.00 Felty's syndrome, unspecified site

☐ M05.30 Rheumatoid heart disease with rheumatoid arthritis of unspecified site

☐ M05.60 Rheumatoid arthritis of unspecified site with involvement of other organs and systems

☐ M06.1 Adult-onset Still's disease ☐ M45.9 Ankylosing spondylitis of unspecified sites in spine

☐ M08.____ Juvenile RA ☐ L40.54 Psoriatic juvenile arthropathy ☐ L40.59 Other psoriatic arthropathy

Date of TB skin test: _____ ESR with date: _____ CRP and Date: _____

PRESCRIPTION

Medication	Dose	Directions	Quantity	Refills
☐ Cimzia®	☐ Cimzia Starter Kit	☐ Induction dose: inject 400mg subcutaneously on day 1, at week 2, and at week 4	1 kit (6 vials)	
	☐ 200mg/1 mL Prefilled Syringe ☐ 200mg vial	☐ Maint. Dose: Inject 200mg subcutaneously every OTHER week. ☐ Maint. Dose: Inject 400mg subcutaneously every 4 weeks. ☐ Other: _____		
☐ Enbrel®*	☐ 50mg/ml Sureclick™ Autoinjector ☐ 50mg/ml Prefilled Syringe ☐ 25mg/0.5ml Prefilled Syringe ☐ 25mg Vial	☐ Inject 50mg subcutaneously ONCE a week. ☐ Inject 25mg subcutaneously TWICE a week (72-96 hours apart). ☐ Other: _____		
☐ Humira®*	☐ 40mg/0.8ml Pen ☐ 40mg/0.8ml Prefilled Syringe ☐ 20mg/0.4ml Prefilled Syringe	☐ Inject 40mg subcutaneously every OTHER week. ☐ Inject 20mg subcutaneously every OTHER week. ☐ Other: _____		
☐ Kineret®	☐ 100mg Prefilled Syringe	☐ Inject 100mg (one syringe) SC once a day.		
☐ Simponi®	☐ 50mg/0.5ml Prefilled SmartJect Autoinjector ☐ 50mg/0.5ml Prefilled Syringe	☐ Inject 50mg (0.5ml) subcutaneously once a month ☐ Other: _____		
☐ Xeljanz®	5mg #60	☐ 1 tablet twice per day		
☐ Actemra®	162mg / 0.9mL Prefilled Syringe	☐ Inject 1 syringe SC every week (≥ 100kg) ☐ Inject 1 syringe SC every other week (< 100kg)		
☐ Otezla®	☐ 28 Day Starter Pack ☐ Bottles of 60	☐ To reduce risk of gastrointestinal symptoms, titrate to recommended dose of 30 mg twice daily according to the following schedule: Day 1: 10mg in morning Day 2: 10mg in morning and 10mg in evening Day 3: 10mg in morning and 20mg in evening Day 4: 20mg in morning and 30mg in evening Day 5: 20mg in morning and 30mg in evening ☐ Maint. Dose: 30mg twice daily		
☐ Stelara®	☐ 45mg Prefilled Syringe ☐ 90mg Prefilled Syringe	☐ Inject 45mg SQ on day 0 then week 4 then every 12 weeks ☐ Inject 90mg SQ on day 0 then week 4 then every 12 weeks		
☐ Other				

Patients must bring an original prescription to the pharmacy. Faxed prescriptions will only be accepted from a prescribing practitioner.

PHYSICIAN SIGNATURE

To Physician: By signing this form and utilizing our services, you are also authorizing pharmacy to serve as your prior authorization agent in dealing with medical and prescription insurance companies, and co-pay assistance foundations.

Physician Signature: **Date**: _____

CONFIDENTIALITY NOTICE