RHEUMATOLOGY ENROLLMENT FORM

Fax to: 1-844-295-5518

DATE:_______________________ SHIP TO:
DATE NEEDED: _________________ ☐ PATIENT ☐ OFFICE

PHARMACY LOCATION
11233 SHADOW CREEK PARKWAY, SUITE 123A
PEARLAND, TEXAS 77584
1.844.295.5516

PATIENT INFO

NAME ______________________ E-MAIL______________________ DOB______________ ☐ MALE ☐ FEMALE

ADDRESS______________________ CITY______________ STATE_______ ZIP__________

HOME TELEPHONE ______________ MOBILE PHONE ______________ SS#______________

PLEASE FAX COPY OF INSURANCE CARD (FRONT & BACK)

CLINICAL INFORMATION

DIAGNOSIS CODES
☐ M06.9 Rheumatoid Arthritis ☐ M08.00 Juvenile Idiopathic Arthritis ☐ M45.9 Ankylosing Spondylitis ☐ L40.52 Psoriatic Arthritis
☐ Date of Diagnosis: ______________ Other: ______________

TREATMENT HISTORY
☐ New to this medicine ☐ Continued Treatment - If continuing treatment, has patient's condition improved or stabilized? ☐ Yes ☐ No
Patient Weight:______kg / lb TB/PPD Test Results? ☐ Negative ☐ Positive ☐ N/A Allergies? ☐ Latex ☐ Other: ______________
Hepatitis B ruled out or being treated? ☐ Yes ☐ No ☐ N/A Concomitant Medications? ☐ Methotrexate ☐ Other: ______________

PRIOR FAILED MEDICATION(S)
Medication ______________ Medication ______________
Length of Treatment ______ to ______ Length of Treatment ______ to ______
Reason for Discontinuing ______________ Reason for Discontinuing ______________

PRESCRIPTION INFORMATION

☐ ACTEMRA®	DIRECTIONS	QUANTITY
☐ 162mg/0.9ml PFS	☐ *(wt <100kg):* Inject 162mg SC every *other* week ☐ *(wt >100kg):* Inject 162mg SC every week ☐ _______mg/kg SC every *other* week ☐ Other______________	☐ 2 PFS/Pen ☐ 4 PFS/Pen Refills_______

☐ CIMZIA®	DIRECTIONS	QUANTITY
Starter: ☐ Starter Kit 200mg PFS ☐ 200mg/ml Vial & Supplies	Starter Directions: ☐ Inject 400mg SC at weeks 0, 2, and 4 ☐ Other:______________	☐ 1 PFS Kit (6x200 mg PFS) ☐ 2 PFS
Maintenance ☐ 200mg/ml PFS ☐ 200mg/ml Vial & Supplies	Maintenance Directions: ☐ Inject 200mg SC every *other* week ☐ Inject 400mg SC every 4 weeks ☐ Other:______________	Refills_______

☐ COSENTYX®	DIRECTIONS	QUANTITY
☐ 150mg/ml PFS ☐ 150mg/ml Pen	Starter: ☐ Ankylosing Spondylitis or Psoriatic Arthritis: Inject 150mg (1 pens / PFS) SC weekly at weeks, 0,1,2,3 and 4, then maintenance dosing.	☐ 5 Pen / PFS ☐ 10 Pens / PFS
	Starter: ☐ Psoriatic Arthritis with Coexistent Plaque Psoriasis : Inject 300mg (2 pens/PFS) SC weekly at weeks 0,1,2,3, and 4, then maintenance.	Refills_______
	Maintenance: ☐ Ankylosing Spondylitis or Psoriatic Arthritis: Inject 150mg SC every 4 weeks. ☐ Other:______________	☐ 1 Pens / PFS ☐ 2 Pens / PFS
	Maintenance: ☐ Psoriatic Arthritis with Coexistent Plaque Psoriasis : Inject 300mg SC every 4 weeks. ☐ Other:______________	Refills_______

☐ ENBREL®	DIRECTIONS	QUANTITY
☐ 50mg/ml SureClick Pen® ☐ 50mg/ml PFS ☐ 25mg/0.5ml PFS ☐ 25mg/0.5ml Vial	☐ Inject 50mg SC once a week ☐ Inject 50mg SC twice a week ☐ Inject 25mg SC twice a week ☐ __0.8mg/kg SC every week ☐ Other:______________	☐ 4 ☐ 8 Refills_______

☐ HUMIRA®	DIRECTIONS	QUANTITY
☐ 40mg/0.8ml Pen ☐ 40mg/0.8ml PFS	☐ Inject 40mg SC every *other* week ☐ Inject 40mg SC once a week ☐ Other______________	☐ 2 ☐ 4 Refills_______

☐ HUMIRA® FOR UVEITIS	DIRECTIONS	QUANTITY
Uveitis Starter ☐ Psoriasis Starter Pen Kit	Uveitis Induction Dose: ☐ Inject two 40mg Pens SC on day 1, then one 40mg Pen on day 8, then one 40mg Pen every other week	☐ 1 Starter Kit
Uveitis Maintenance Dose: ☐ 40mg/0.8ml Pen ☐ 40mg/0.8ml PFS	Uveitis Maintenance Directions: ☐ Inject one 40mg dose SC every other week ☐ Other:______________	☐ 2 Pens/PFS ☐ ______ Refills______

☐ ORENCIA®	DIRECTIONS	QUANTITY
☐ 250mg/15ml Vial ☐ 125mg/ml PFS ☐ 125mg/ml ClickJect™ Pen	Starter: ☐ Initial: Infuse ________mg IV, then inject 125mg SC within 24 hrs Maintenance: ☐ Inject 125mg SC once a week ☐ Other______________	☐ 1 Vial ☐ 4 PFS / Pens ☐ ______ Refills_______

☐ OTEZLA®	DIRECTIONS	QUANTITY
☐ Starter/Titration Pack	(Use Otezla START form for bridge dosage) Starter: ☐ Take as directed on Starter Pack	☐ Starter Pack ☐ 30
☐ 30mg Tablet	Maintenance Treatment (30mg) ☐ Take 1 tablet by mouth TWICE a day ☐ Take 1 tablet by mouth ONCE a day ☐ Other:______________	☐ 60 ☐ ______ Refills_______

☐ REMICADE®	DIRECTIONS	QUANTITY
☐ 100mg/20ml Vial	Starter: Administer _____mg kg at 0,2, and 6 weeks, then maintenance dosing Maintenance: ☐ Administer _____mg/kg every_____ weeks ☐ Other:______________	☐ _____ Vials Refills_______

☐ SIMPONI®	DIRECTIONS	QUANTITY
☐ 50mg/0.5ml SmartJect® (Pen) ☐ 50mlg/0.5ml PFS	☐ Inject 50mg SC once a month ☐ Other:______________	☐ 1 Refills_______

☐ SIMPONI® ARIA®	DIRECTIONS	QUANTITY
☐ 50mg/4ml vial	Starter: ☐ Infuse _______mg (2mg/kg) IV at weeks 0 and 4, then maintenance dosing. Maintenance: ☐ Infuse _______mg (2mg/kg)IV every 8 weeks. ☐ Other:______________	☐ _____Vials Refills_______

☐ STELARA®	DIRECTIONS	QUANTITY
☐ 45mg/0.5ml PFS ☐ 90mg/1ml PFS	Starter: ☐ Inject 1 PFS SC on Day 1 Maintenance: ☐ Inject 1 PFS 4 weeks after start of treatment, then every 12 weeks thereafter ☐ Other:______________	☐ 1 Refills_______

☐ XELJANZ®	DIRECTIONS	QUANTITY
☐ 5mg Tablet	☐ Take 5mg PO twice daily	☐ 60 | Refills_____

☐ XELJANZ XR®	DIRECTIONS	QUANTITY
☐ 11mg Tablet	☐ Take 1 tablet PO once daily	☐ 30 | Refills_____

GOUT AGENTS	DIRECTIONS	QUANTITY
☐ KRYSTEXXA® ☐ 8mg/ml Vial	☐ Administer 8mg via iv infusion over 2 hours every 2 weeks: ☐ Other:______________	☐ 2 vials Refills_______

INJECTION TRAINING ☐ Patient has received injection training ☐ Physician Office to provide injection training ☐ Pharmacy to provide injection training

PRESCRIBER INFORMATION

Prescriber's Name: ______________________ Contact Person:______________
Telephone: ______________ Fax:______________ Email:______________
Office Address: ______________________ City:______________ State: ______ Zip:________
NPI # : ______________ DEA # : ______________ TAX ID # : ______________ Medicaid Provider # :______________

______________________ __________ * ______________________
PRESCRIBER'S SIGNATURE (DATE) *IF BRAND DRUGS ARE PREFERRED, HANDWRITE **"BRAND MEDICALLY NECESSARY"**

I authorize the Pharmacy noted above and its representatives to act as an agent to initiate and execute the insurance

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