



ENROLLMENT FORM

Fax to: 844.295.5518

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

DATE: _____ SHIP TO:
DATE NEEDED: _____ PATIENT OFFICE

PATIENT INFO
Name: _____
Address: _____ City, State, Zip: _____
Home Telephone: _____ Mobile Phone: _____ SS#: _____

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

CLINICAL INFORMATION
• Diagnosis: _____ • Date of diagnosis: _____
 M06.9 Rheumatoid Arthritis L40.54 Psoriatic Arthritis
 L40.54 Juvenile Idiopathic Arthritis M81.0 Postmenop Osteo.
 M45.9 Ankylosing Spondylitis Other: _____
• Treatment History: new to this medicine continued treatment
• Concomitant medications? methotrexate Other: _____
• Patient weight: _____ lb kg
• TB/PPD Test Results? Negative Positive Not applicable
• Hepatitis B ruled out or being treated? Yes No N/A
• Allergies? Latex Other: _____

Comments: _____

Prior Failed Medication(s)	Length of Treatment	Reason for Discontinuing
_____	_____ to _____	_____
_____	_____ to _____	_____
_____	_____ to _____	_____

Drug	Dosage form/strength	Directions	Quantity	Refills
------	----------------------	------------	----------	---------

RHEUMATOLOGY

Cimzia®	Maintenance Dose: <input type="checkbox"/> Prefilled Syringe (200mg/ml)	Maintenance Directions: <input type="checkbox"/> Inject 400mg SC every 4 weeks <input type="checkbox"/> Inject 200mg SC every <u>other</u> week	<input type="checkbox"/> 2 prefilled syr Other: _____	
Cytoxan Cyclophosphamide	<input type="checkbox"/> 500mg vial <input type="checkbox"/> 1 gram vial <input type="checkbox"/> 2 gram vial	<input type="checkbox"/> Administer _____mg/kg via IV infusion every _____	<input type="checkbox"/> _____ vials	
Orencia®	<input type="checkbox"/> Vial (250mg/15ml)	<input type="checkbox"/> IV only: Infuse _____mg IV at weeks 0, 2, and 4, and every 4 weeks thereafter	<input type="checkbox"/> _____ vials	
Remicade®	<input type="checkbox"/> Vial (100mg/20ml)	<input type="checkbox"/> Administer _____/mg/kg at 0,2 & _____ wks, then q_____ wks after <input type="checkbox"/> Maintenance: Administer _____mg/kg every _____ weeks	<input type="checkbox"/> _____ vials <input type="checkbox"/> _____ vials	
Simponi Aria®	<input type="checkbox"/> 50mg/4ml vial	<input type="checkbox"/> Administer 2 mg/kg via IV inf at weeks 0& 4, then Q8 wks thereafter <input type="checkbox"/> Other: _____	<input type="checkbox"/> _____ vials	

OSTEOPOROSIS

Boniva® ibandronate sodium	<input type="checkbox"/> Prefilled Syringe (3mg/3ml)	<input type="checkbox"/> Administer 3mg via IV injection over 15-30 seconds every 3 months <input type="checkbox"/> Other: _____	<input type="checkbox"/> 1 syringe	
Reclast® zoledronic acid	<input type="checkbox"/> Vial (5mg/100ml)	Infuse 5mg IV, over no less than 15 minutes, every year <input type="checkbox"/> Infuse 5mg IV, over no less than 15 minutes, every 2 years	<input type="checkbox"/> 1 syringe	

OTHER MEDICATIONS

PRESCRIBER INFORMATION
Practitioner's Name: _____ Contact person: _____
Telephone: _____ Fax: _____
Office Address: _____ City: _____ State: _____ Zip: _____
NPI#: _____ DEA#: _____ Medicaid Provider #: _____

PRODUCT SUBSTITUTION PERMITTED (DATE) DISPENSE AS WRITTEN (DATE)

I authorize ReCept Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

IMPORTANT NOTICE: This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee. Ref.028.HC.1.15