HILL COUNTRY PHARMACY

ENROLLMENT FORM

Fax to: 844.295.5518

DATE: _____
DATE NEEDED: _____

SHIP TO: ☐ PATIENT ☐ OFFICE

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

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
- ☐ L40.54Juvenile 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	

PRESCRIPTION INFORMATION

Drug	Dosage form/strength	Directions	Quantity	Refills
RHEUMATOLOGY				
Cimzia®	**Maintenance Dose:** ☐ Prefilled Syringe (200mg/ml)	**Maintenance Directions:** ☐ Inject 400mg SC every 4 weeks ☐ Inject 200mg SC every *other* week	☐ 2 prefilled syr Other:	
Cytoxan Cyclophosphamide	☐ 500mg vial ☐ 1 gram vial ☐ 2 gram vial	☐ Administer _____mg/kg via IV infusion every _____	☐ ____ vials	
Orencia®	☐ Vial (250mg/15ml)	☐ **IV only:** Infuse _____mg IV at weeks 0, 2, and 4, and every 4 weeks thereafter	☐ ____ vials	
Remicade®	☐ Vial (100mg/20ml)	☐ Administer _____/mg/kg at 0,2 & _____ wks, then q_____ wks after ☐ **Maintenance:** Administer ____mg/kg every ____ weeks	☐ ____ vials ☐ ____ vials	
Simponi Aria®	☐ 50mg/4ml vial	☐ Administer 2 mg/kg via IV inf at weeks 0& 4, then Q8 wks therafter ☐ Other:	☐ ____ vials	
OSTEOPOROSIS				
Boniva® ibandronate sodium	☐ Prefilled Syringe (3mg/3ml)	☐ Administer 3mg via IV injection over 15-30 seconds every 3 months ☐ Other:	☐ 1 syringe	
Reclast® zoledronic acid	☐ Vial (5mg/100ml)	Infuse 5mg IV, over no less than 15 minutes, every year ☐ Infuse 5mg IV, over no less than 15 minutes, every 2 years	☐ 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.