

Rheumatology Subcutaneous Enrollment Form

Fax Referral To: 844-504-3278
Phone: 877-327-8881

Please cut along the dotted lines before submitting to a pharmacy.

Date Required: _____ Ship To: Patient MD Office Other: _____

PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name: _____	Prescriber Name: _____
Address: _____	Address: _____
City, State, Zip: _____	City, State, Zip: _____
Home Phone: _____	Phone: _____
Cell Phone: _____	Fax: _____
Date of Birth: _____ Gender: _____	DEA #: _____ NPI #: _____
Emergency Contact: _____ Phone: _____	Contact Person: _____

INSURANCE INFORMATION (Please attach the front and back of insurance and prescription drug card.)

Primary Insurance: _____ ID: _____ Group: _____
 Secondary Insurance: _____ ID: _____ Group: _____
 Prescription Card: _____ ID: _____ BIN: _____ PCN: _____

To better serve your patient and facilitate insurance authorization, please complete the pertinent sections:

PATIENT DIAGNOSIS/CLINICAL INFORMATION	
M06.9 Rheumatoid Arthritis	TB/PPD Test: Positive Negative Date Read: _____
M45.9 Ankylosing Spondylitis	Forteo T-score: _____ Type: _____ Date: _____ Site: _____
M32.10 Systemic Lupus Erythematosus	Fractured: _____ Date: _____
L40.50 Psoriatic Arthritis	Weight: _____ kg lbs Height: _____ cm in %BSA: _____
Other: _____	Allergies: _____ NKDA
Prior Medication Failed: _____	Injection Training/Home Health RN visit is necessary: Yes No
Length of Treatment: _____	Site of Care: Home MD Office Other: _____
Reason for Discontinuation: _____	

PRESCRIPTION INFORMATION

Medication:	Dose/Strength:	Directions:	Quantity:	Refills:
Actemra®	162mg PFS	Inject 162mg every other week (under 100kg) Inject 162mg every week (over 100kg)	1 month supply	
Benlysta®	200mg Autoinjector 200mg PFS	Inject 200mg SUBQ ONCE a week	4 week supply	
Cimzia®	200mg X2 PFS	Inject 400mg SUBQ at weeks 0, 2, and 4 Inject 400mg once monthly Inject 200mg every other week	1 month supply	
Cosentyx®	300mg (2x150) Pen PFS 150mg Pen PFS	Load: Inject 300mg or 150mg SUBQ week 0,1,2,3,4 Maintenance: Inject 300mg or 150mg SUBQ every 4 weeks	5 week supply 4 week supply	
Enbrel®	50mg Sureclick 25mg Vials 50mg PFS 25mg PFS Mini™ with Autotouch™	Inject 50mg once weekly Inject 50mg twice weekly Inject 25mg once weekly Inject 25mg twice weekly	1 month supply	
Forteo®	750µg per 3mL pen and supplies	Inject 20 µg SUBQ once daily	1 month supply	
Humira®	40mg Pen 40mg PFS	Inject 40mg SUBQ once a week Inject 40mg SUBQ every other week	1 month supply	
Kevzara®	150mg PFS 200mg PFS	Inject one PFS SUBQ every 2 weeks	1 month supply	
Methotrexate	2.5mg tab 25mg per mL vial	Take _____mg by mouth once weekly Inject _____mg SUBQ once weekly	1 month supply	
Orencia®	125mg PFS 250mg Vial	Inject 125mg once weekly Inject _____mg once monthly	1 month supply	
Otezla®	30mg tablet Starter Pack	Take 1 tablet by mouth twice daily Take as per package instructions	1 month supply	
Otrexup®	_____mg per 0.4mL	Inject _____mg once weekly	1 month supply	
Rasuvo®	_____mg	Inject _____mg once weekly	1 month supply	
Simponi®	50mg Smartject 50mg PFS	Inject 50mg SUBQ once monthly	1 month supply	
Stelara®	45mg vials 90mg (2 x 45mg vials)	Inject 45mg SUBQ at week 0 and week 4, then inject 45mg SUBQ every 12 weeks Inject 90mg SUBQ at week 0 and week 4, then inject 90mg SUBQ every 12 weeks	1 month supply	
Xeljanz®	5mg tablet XR 11mg tablet	Take 1 tablet by mouth twice daily Take 1 tablet by mouth once daily	1 month supply	
Other:				

By signing this form and using this pharmacy's services, you are authorizing this pharmacy to serve as your prior authorization designated agent in dealing with prescription and medical insurance companies.

Prescriber Signature: _____ Date: _____

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