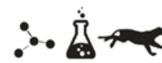
Rheumatology Enrollment Form (F-Q)



PATIENT INFORMATION

Patient Name: ______________________________________
Date of Birth: ____ /____ / ____ ☐ Male ☐ Female
SSN: ____ -____ - ____
Address: ______________________________________
City: _____________ State: _____ Zip: _______________

Phone: (____) - ____ - ________
email: ____
Preferred method of contact: ☐ Phone ☐ Email
Height: ________ in Weight: ________ lb Date: ____ /____ / ____
Allergies: Medications: (Please attach additional pages if necessary)

PRESCRIPTION BENEFITS INFORMATION (Please attach front and back of insurance card)

Plan name: __________________ ID#: ________________________ Group #: ______________ RxBIN: _________ RxPCN: _________

PRESCRIBER INFORMATION

Prescriber Name: _________________________________
Address: ______________________________________
City: ____________ State: _____ Zip: ______________
Contact: _______________________
Clinic/Hospital Affiliation: ___________________________

Phone: (____) - ____ - ________
Fax: (____) - ____ - ________
License #: ________________________
NPI #: _____________________
Medicaid Provider #: ________________________

RAFQRX 18.01

CLINICAL CONSIDERATIONS

Diagnosis:
☐ M06.9 Rheumatoid Arthritis, unspecified
☐ L40.59 Psoriatic Arthritis
☐ M45.9 Ankylosing Spondylitis
☐ Other: _____________

Prior Therapies (please include dates)
☐ Corticosteroids Date: ____ /____ / ____
☐ Hydroxychloroquine Date: ____ /____ / ____
☐ Methotrexate Date: ____ /____ / ____
☐ Celebrex® Date: ____ /____ / ____
☐ Sulfasalazine Date: ____ /____ / ____
☐ Azathioprine Date: ____ /____ / ____
☐ Humira® Date: ____ /____ / ____
☐ Enbrel® Date: ____ /____ / ____
☐ Other: Date: ____ /____ / ____

Immunization History
☐ Influenza
Date: ____ /____ / ____
Hep B Screening:
☐ Pos. ☐ Neg.
Date: ____ /____ / ____
TB Test Completed: ☐ Yes ☐ No
Date of negative test: ____ /____ / ____
If history of latent TB, has patient received treatment?
☐ Yes ☐ No

Rx

Medication	Dose/Strength	Directions	Quantity	Refills
Humira® (adalimumab)	☐ 40 mg pen ☐ 40 mg prefilled syringe	☐ Inject 40 mg subcutaneously every week ☐ Inject 40 mg subcutaneously every other week		
Inflectra® (infliximab-dyyb)	☐ 100 mg vial *Patient Dosing Weight:* _____kg	☐ **Initial**: Infuse ___ mg/kg in 250 mL of 0.9% NaCl at weeks 0, 2, and 6, then maintenance dose ☐ **Maintenance**: Infuse ___ mg/kg in 250 mL of 0.9% NaCl every 6 weeks ☐ **Maintenance**: Infuse ___ mg/kg in 250 mL of 0.9% NaCl every 8 weeks		
Kevzara® (sarilumab)	☐ 150 mg prefilled syringe ☐ 200 mg prefilled syringe	☐ Inject 150 mg subcutaneously every 2 weeks (if lab abnormalities) ☐ Inject 200 mg subcutaneously every 2 weeks		
Olumiant® (baricitinib)	☐ 2 mg tablets	☐ Take one tablet by mouth once daily		
Orencia® (abatacept)	☐ 125 mg prefilled syringe ☐ 125 mg autoinjector	☐ Inject 125 mg subcutaneously every week		
Otezla® (apremilast)	**Initial Dose** ☐ 28-day starter pack (titration)	☐ **Day 1:** 10 mg PO QAM. **Day 2:** 10 mg PO BID. **Day 3:** 10 mg PO QAM and 20 mg PO QPM. **Day 4:** 20 mg PO BID. **Day 5:** 20 mg PO QAM and 30 mg QPM. **Day 6 and thereafter:** 30 mg PO BID.	55 tablets	0
	Maintenance Dose ☐ 30 mg tablets	☐ Take one tablet by mouth once daily (renal impairment) ☐ Take one tablet by mouth twice daily		

Injection Training
Injection training provided by ☐ Prescriber's Office ☐ Specialty Pharmacy ☐ Other: ___________________

By signing below, I authorize the pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.
I also certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge.

Prescriber's signature: ________________________________ ☐ MD ☐ DO ☐ PA ☐ CRNP **Date:** ____ /____ / ____
NO STAMPS

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary" on the prescription.

SHIPPING INFORMATION

Ship to: ☐ Patient ☐ Physician/Clinic Date Shipment Needed By: ____ /____ / ____

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