Rheumatology Enrollment Form (R-Z)

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 #: _____

PARZRX-17.03

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

℞

Medication	Dose/Strength	Directions	Quantity	Refills
Remicade® (infliximab)	☐ 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		
Renflexis™ (infliximab-abda)	☐ 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		
Simponi® (golimumab)	☐ 50 mg autoinjector ☐ 50 mg prefilled syringe	☐ Inject 50 mg subcutaneously once a month		
Stelara® (ustekinumab)	☐ 45 mg prefilled syringe	☐ **Initial**: Inject 45 mg subcutaneously at 0 and 4 weeks, then maintenance dose ☐ **Maintenance**: Inject 45 mg subcutaneously every 12 weeks		
	☐ 90 mg prefilled syringe *****Weight must be greater than 100 kg*****	☐ **Initial**: Inject 90 mg subcutaneously at 0 and 4 weeks, then maintenance dose ☐ **Maintenance**: Inject 90 mg subcutaneously every 12 weeks		
Taltz® (ixekizumab)	☐ 80 mg autoinjector ☐ 80 mg prefilled syringe	☐ **Initial:** Inject 160 mg (2 x 80 mg) subcutaneously at week 0, 80 mg at week 4, then maintenance dose ☐ **Maintenance:** Inject 80 mg subcutaneously every 4 weeks		
Xeljanz® (tofacitinib)	☐ 5 mg tablets	☐ Take one tablet by mouth twice daily ☐ Other:		
Xeljanz® XR (tofacitinib)	☐ 11 mg tablets	☐ Take one tablet by mouth once 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: ____ /____ / ____