RHEUMATOID ARTHRITIS ENROLLMENT FORM

Fax Referral To: 252-726-0792 Phone: 844-418-9857

PATIENT INFORMATION:

Name:_____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Alt. Phone: _____
Email: _____
DOB: _____ Gender: ○ M ○ F Caregiver: _____
Height: _____ Weight: _____ Allergies: _____

PRESCRIBER INFORMATION:

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____
NPI: _____ DEA: _____
Tax ID: _____
Office Contact: _____ Phone: _____

DIAGNOSIS AND CLINICAL INFORMATION Needs by Date: _____

☐ M06.9 (Rheumatoid Arthritis) ☐ M08.0 (Juvenille Idiopathic Arthiritis) ☐ L40.59 (Psoriatic Arthritis)
☐ L40.54 (Psoriatic Juvenille Arthritis) ☐ M45.9 (Ankylosing Spondylitis) ☐ _____
Diagnosis Date: _____ TB Test: ☐ Yes ☐ No Negative Test Date: _____
Prior Therapy ☐ Yes ☐ No _____
Reason for Discontinuation of Therapy: _____
_____
Approximate Start Date: _____ Approximate End Date: _____
Comorbidities: _____
Concomitant Medications: _____

PRESCRIPTION INFORMATION

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Cimzia®	☐ Cimzia Starter Kit (6 Prefilled Syringes)	☐ Induction Dose: Inject 400 mg SC on day 1, at week 2, and at week 4.	1 Kit	0
	☐ 200 mg/1 mL Prefilled Syringe ☐ 200 mg vial	☐ Maintenance Dose: Inject 200 mg SC every OTHER week. ☐ Maintenance Dose: Inject 400 mg SC every four weeks. ☐ Other: _____		
☐ Enbrel®	☐ 25 mg/0.5 mL Prefilled Syringe ☐ 25 mg vial ☐ 50 mg/mL Sureclick™ Autoinjector ☐ 50 mg/mL Prefilled Syringe	☐ Inject 25 mg SC TWICE a week (72 to 96 hours a apart). ☐ Inject 50 mg SC ONCE a week. ☐ Other: _____		
☐ Humira®	☐ 20 mg/0.4 mL Prefilled Syringe ☐ 40 mg/0.8 mL Prefilled Syringe ☐ 40 mg/0.8mL pen	☐ Inject 20 mg SC every OTHER week. ☐ Inject 40 mg SC every OTHER week. ☐ Other: _____		
☐ Otezla®	☐ Titration Starter Pack	Day 1: 10 mg PO in the morning. Day 2: 10 mg PO in the morning and 10 mg PO in the evening. Day 3: 10 mg PO in the morning and 20 mg PO in the evening. Day 4: 20 mg PO in the morning and 20 mg PO in the evening. Day 5: 20 mg PO in the morning and 30 mg PO in the evening. Day 6 and thereafter: 30 mg PO twice daily.		
	☐ 30 mg vial	☐ Maintenance Dose: 30 mg tablet orally twice daily. ☐ Other: _____		
☐ Simponi®	☐ 50 mg/0.5 mL Prefilled SmartJect Autoinjector ☐ 50 mg/0.5 mL Prefilled Syringe	Inject 50 mg SC once a month.		
☐ Stelara®	☐ 45 mg/0.5mL Prefilled Syringe ☐ 90 mg/mL Prefilled Syringe	☐ For patients weighing ≤100 kg (220 lbs): Inject 45 mg SC initially and 4 weeks later followed by 45 mg every 12 weeks. ☐ For patients weighing >100 kg (220 lbs): Inject 90 mg SC initially and 4 weeks later followed by 90 mg every 12 weeks.		
☐ Xeljanz®	☐ 5 mg Tablet	☐ Take one 5 mg tablet by mouth twice a day	60	
☐ Xeljanz® XR	☐ 11 mg Tablet	☐ Take one 11 mg tablet twice a day	30	
☐ Other				

PRODUCT DELIVERY: ○ Patient's Home ○ Physician's Office ○ Pharmacy to Coordinate

INSURANCE INFORMATION: Please Include Front and Back Copies of Pharmacy and Medical Card

By signing this form, you are authorizing Medical Park Pharmacy and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

_____ _____ _____ _____
PRODUCT SUBMISSION PERMITTED Date DISPENSE AS WRITTEN Date