



# Rheumatology Enrollment Form

Fax: 909-284-9140

Phone: 909-266-0016

## PATIENT INFORMATION

Please complete the following or send patient demographic sheet

Patient Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 Address 2 \_\_\_\_\_  
 City, State, Zip \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Mobile Phone \_\_\_\_\_  
 DOB \_\_\_\_\_ Last Four of SS \_\_\_\_\_ Gender \_\_\_\_\_  
 Language Preference \_\_\_\_\_

## PRESCRIBER INFORMATION

Prescriber Name \_\_\_\_\_  
 DEA \_\_\_\_\_  
 NPI \_\_\_\_\_  
 Address \_\_\_\_\_  
 City, State, Zip \_\_\_\_\_  
 Phone \_\_\_\_\_ Fax \_\_\_\_\_  
 Contact Person \_\_\_\_\_

**Clinical Diagnosis: please fax or email relevant clinical notes, labs, tests, and previous medical history to expedite prior authorization**

Diagnosis / ICD 10: _____	Prior Treatment Date: _____	TB/PPD Test <input type="checkbox"/> Yes <input type="checkbox"/> No Results
Date of Diagnosis or Years with Disease _____	Is patient currently on therapy? <input type="checkbox"/> Y <input type="checkbox"/> N	Weight _____ kg/lbs Height _____ cm/in
Has patient been previously treated? <input type="checkbox"/> Y <input type="checkbox"/> N	Will patient terminate current therapy upon start of new prescription? <input type="checkbox"/> Y <input type="checkbox"/> N	

## PRESCRIPTION INFORMATION

Type	Medication	Dose/Strength	Directions	Quantity	Refill
TNF Blocker	<input type="checkbox"/> Cimzia	<input type="checkbox"/> 200mg Starter Kit (6x 200mg PFS) <input type="checkbox"/> 2 x 200mg Prefilled Syringe	<input type="checkbox"/> Inject 400mg SQ once. Repeat weeks 2 & 4 <input type="checkbox"/> Inject 200mg SQ once every 2 weeks <input type="checkbox"/> Inject 400mg SQ once every 4 weeks	<input type="checkbox"/> 4-week supply	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 11 <input type="checkbox"/> _____
	<input type="checkbox"/> Enbrel	<input type="checkbox"/> 25mg Prefilled Syringe <input type="checkbox"/> 50mg/ ml Sureclick Autoinjector <input type="checkbox"/> 50mg Prefilled Syringe	<input type="checkbox"/> Inject 25mg twice weekly. 72 -96 hours apart <input type="checkbox"/> Inject 50mg SQ once weekly <input type="checkbox"/> Other _____	<input type="checkbox"/> 4-week supply	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 11 <input type="checkbox"/> _____
	<input type="checkbox"/> Humira CF	<input type="checkbox"/> 40mg/0.4 ml Pen <input type="checkbox"/> 40mg/0.4 ml Prefilled Syringe <input type="checkbox"/> Psoriasis Starter Pack <input type="checkbox"/> Crohn's Starter Pack	<input type="checkbox"/> Inject 40mg SQ every other week <input type="checkbox"/> Inject 40mg SQ once weekly <input type="checkbox"/> Inject 80mg SQ on day 1 then inject 40mg on day 8 then inject 40mg every other week thereafter <input type="checkbox"/> Inject 160mg SQ on day 1 then inject 80mg on day 15 then start maintenance dose	<input type="checkbox"/> 4-week supply <input type="checkbox"/> 1 starter pack	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 11 <input type="checkbox"/> _____
	<input type="checkbox"/> Inflectra	<input type="checkbox"/> 100mg/20 ml vial	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 11 <input type="checkbox"/> _____
	<input type="checkbox"/> Remicade	<input type="checkbox"/> 100mg/ 20 ml vial	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 11 <input type="checkbox"/> _____
	<input type="checkbox"/> Simponi	<input type="checkbox"/> 50mg/0.5ml Prefilled Syringe <input type="checkbox"/> 50mg/0.5ml Autoinjector	<input type="checkbox"/> Inject 50mg SQ once a month	<input type="checkbox"/> 4-week supply	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 11 <input type="checkbox"/> _____
	<input type="checkbox"/> Simponi Aria	<input type="checkbox"/> 50mg/4 ml single-use vial	<input type="checkbox"/> 2mg/kg IV over 30 minutes at weeks 0 and 4, then every 8 weeks thereafter <input type="checkbox"/> 2mg/kg over 30 minutes every 8 weeks	<input type="checkbox"/> 4-week supply	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 11 <input type="checkbox"/> _____
IL-6 Antagonist	<input type="checkbox"/> Actemra	<input type="checkbox"/> 162mg/0.9 ml PFS	<input type="checkbox"/> Inject 1 syringe SQ once weekly <input type="checkbox"/> Inject 1 Syringe SQ every other week	<input type="checkbox"/> 4-week supply	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 11 <input type="checkbox"/> _____
		IV infusion <input type="checkbox"/> 80mg/4 ml (20mg/ml) <input type="checkbox"/> 200mg/10ml (20mg/ml) <input type="checkbox"/> 400mg/20ml (20mg/ml) in a single dose vial for further dilution prior to IV infusion	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 11 <input type="checkbox"/> _____
IL-17A Antagonist	<input type="checkbox"/> Cosentyx	<input type="checkbox"/> 150mg/ml single use Sensoready pen <input type="checkbox"/> 150mg/ml single-use prefilled syringe <input type="checkbox"/> 300mg lyophilized powder in a single use vial for reconstitution	<input type="checkbox"/> 150mg SQ at weeks 0,1,2,3, & 4 and every 4 weeks thereafter <input type="checkbox"/> 150mg SQ every 4 weeks <input type="checkbox"/> 300mg SQ every 4 weeks	<input type="checkbox"/> 4-week supply	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 11 <input type="checkbox"/> _____
		<input type="checkbox"/> Taltz <input type="checkbox"/> 80mg Auto-Injector Starter Kit (3 pens) <input type="checkbox"/> 80mg Auto-Injector (2 pens) <input type="checkbox"/> 80mg Auto-Injector (1 pen) <input type="checkbox"/> 80mg Prefilled Syringe (1 syringe)	<input type="checkbox"/> 160mg SQ on day 1, then followed by 80mg every 4 weeks thereafter <input type="checkbox"/> 80mg SQ every 4 weeks	<input type="checkbox"/> 4-week supply	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 11 <input type="checkbox"/> _____
IL-12,23 Antagonist	<input type="checkbox"/> Stelara	<input type="checkbox"/> 45 mg Prefilled Syringe <input type="checkbox"/> 90 mg Prefilled Syringe	<input type="checkbox"/> Inject SQ weeks 0,4, and every 12 weeks thereafter <input type="checkbox"/> Inject 1 syringe SQ every 12 weeks	<input type="checkbox"/> 4-week supply	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 11 <input type="checkbox"/> _____
IL-23 Antagonist	<input type="checkbox"/> Tremfya	<input type="checkbox"/> 100 mg/ml Prefilled Syringe <input type="checkbox"/> 100 mg/ml Pen	<input type="checkbox"/> Inject 100mg SQ at weeks 0 and 4 (starter) <input type="checkbox"/> Inject 100mg SQ every 8 weeks	<input type="checkbox"/> 4-week supply	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 11 <input type="checkbox"/> _____
T cell Co-stimulation Modulator	<input type="checkbox"/> Orencia	<input type="checkbox"/> 125 mg/ml Prefilled Syringe <input type="checkbox"/> 125 mg/ml Clickjet Autoinjector (pen) <input type="checkbox"/> 250mg/ 15ml vial (IV only)	<input type="checkbox"/> Inject 125 mg SQ once weekly <input type="checkbox"/> Infuse _____ mg IV every 4 weeks	<input type="checkbox"/> 4-week supply	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 11 <input type="checkbox"/> _____

Ship to:  Patient  Office  Other \_\_\_\_\_ Date: \_\_\_\_\_ Need by Date \_\_\_\_\_

**\* Prescriber Authorization:** I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s) and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorizations forms and the receipt and submission of patient tab values and other patient data, in the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize the pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

Product Substitution permitted  Dispense as Written

Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

CONFIDENTIALITY STATEMENT: This communication is intended for use of the individual or entity to which it is addressed and may contain information that is privileged, confidential, and exempt from disclosure under applicable law. If the reader of this communication is not the intended recipient or the employee or agent responsible for delivery of the communication, you are hereby notified that any dissemination, distribution, or copying of the communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone.



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Diagnosis / ICD 10: _____	Prior Treatment Date: _____	TB/PPD Test <input type="checkbox"/> Yes <input type="checkbox"/> No Results _____
Date of Diagnosis or Years with Disease _____	Is patient currently on therapy? <input type="checkbox"/> Y <input type="checkbox"/> N	Weight _____ kg/lbs Height _____ cm/in
Has patient been previously treated? <input type="checkbox"/> Y <input type="checkbox"/> N	Will patient terminate current therapy upon start of new prescription? <input type="checkbox"/> Y <input type="checkbox"/> N	
T-Score Results: _____	History of Fractures: _____	

## PRESCRIPTION INFORMATION

Type	Medication	Dose/Strength	Directions	Quantity	Refill
CD 20-directed cytolytic antibody	<input type="checkbox"/> Riabni <input type="checkbox"/> Rituxan <input type="checkbox"/> Ruxience <input type="checkbox"/> Truxima	<input type="checkbox"/> 10mg /ml	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 11 <input type="checkbox"/> _____
PDE 4 inhibitor	<input type="checkbox"/> Otezla	<input type="checkbox"/> Starter Pack <input type="checkbox"/> 30mg tablets	<input type="checkbox"/> Take as directed <input type="checkbox"/> Take 1 tablet PO twice daily	<input type="checkbox"/> 1 pack <input type="checkbox"/> 60 tablets	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 11 <input type="checkbox"/> _____
JAK inhibitor	<input type="checkbox"/> Olumiant	<input type="checkbox"/> 2 mg tablets	<input type="checkbox"/> Take 2mg PO once daily	<input type="checkbox"/> 30 tablets	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 11 <input type="checkbox"/> _____
	<input type="checkbox"/> Rinvoq	<input type="checkbox"/> 15 mg tablets	<input type="checkbox"/> Take 15mg PO once daily	<input type="checkbox"/> 30 tablets	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 11 <input type="checkbox"/> _____
	<input type="checkbox"/> Xeljanz	<input type="checkbox"/> 5mg tablets	<input type="checkbox"/> Take 5mg PO twice daily	<input type="checkbox"/> 60 tablets	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 11 <input type="checkbox"/> _____
	<input type="checkbox"/> Xeljanz XR	<input type="checkbox"/> 11mg tablets	<input type="checkbox"/> Take 11mg PO once daily	<input type="checkbox"/> 30 tablets	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 11 <input type="checkbox"/> _____
rhPTH (1-34)	<input type="checkbox"/> Forteo <input type="checkbox"/> BD Ultra Fine Pen Needles	<input type="checkbox"/> 600 mcg/2.4 ml Prefilled Syringe	<input type="checkbox"/> Inject 20 mcg SQ as directed once daily	<input type="checkbox"/> 4-week supply	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 11 <input type="checkbox"/> _____
PTH1R agonist	<input type="checkbox"/> Tymlos <input type="checkbox"/> BD Ultra Fine Pen Needles	<input type="checkbox"/> 80mcg Prefilled Syringe	<input type="checkbox"/> Inject 80 mcg SQ once daily	<input type="checkbox"/> 4-week supply	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 11 <input type="checkbox"/> _____
RANK L inhibitor	<input type="checkbox"/> Prolia	<input type="checkbox"/> 60mg Prefilled Syringe	<input type="checkbox"/> Inject 60mg SQ once every 6 months		<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 11 <input type="checkbox"/> _____
BLyS inhibitor	<input type="checkbox"/> Benlysta	<input type="checkbox"/> 120 mg/5ml single-dose vial <input type="checkbox"/> 400mg/20ml single-dose vial <input type="checkbox"/> 200mg/ml single-dose prefilled autoinjector <input type="checkbox"/> 200mg/ml single-dose prefilled syringe	<input type="checkbox"/> 10mg/kg IV at 2-week intervals for the first 3 doses and at 4-week intervals thereafter  <input type="checkbox"/> 200mg SQ once weekly	<input type="checkbox"/> 4-week supply	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 11 <input type="checkbox"/> _____
Interferon Receptor Antagonist, Type I	<input type="checkbox"/> Saphnelo	<input type="checkbox"/> 300mg/2ml Single-dose vial	<input type="checkbox"/> Infuse 300mg intravenously over 30 minutes every 4 weeks	<input type="checkbox"/> 4-week supply	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 11 <input type="checkbox"/> _____
Pegylated uric acid specific enzyme	<input type="checkbox"/> Krystexxa	<input type="checkbox"/> 8mg/ml vial	<input type="checkbox"/> 8mg given as an intravenous infusion every 2 week for chronic Gout	<input type="checkbox"/> _____	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 11 <input type="checkbox"/> _____
Bisphosphonate	<input type="checkbox"/> Zoledronic Acid	<input type="checkbox"/> 5mg in a 100 ml ready-to-infuse solution	<input type="checkbox"/> Infuse 5mg/100 ml IV over 30 minutes	<input type="checkbox"/> _____	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 11 <input type="checkbox"/> _____
Corticosteroid	<input type="checkbox"/> Rayos	<input type="checkbox"/> 1mg tablets <input type="checkbox"/> 2mg tablets <input type="checkbox"/> 3mg tablets	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 11 <input type="checkbox"/> _____
Interleukin-1B blocker	<input type="checkbox"/> Ilaris	<input type="checkbox"/> 150mg/mL sdv	<input type="checkbox"/> 4mg/kg SQ every 4 weeks	<input type="checkbox"/> 4-week supply	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 11 <input type="checkbox"/> _____
Other	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 11 <input type="checkbox"/> _____

Ship to:  Patient  Office  Other Date: \_\_\_\_\_ Need by Date \_\_\_\_\_

\* Prescriber Authorization: I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s) and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorizations forms and the receipt and submission of patient tab values and other patient data, in the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize the pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

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