Rheumatology Enrollment Form

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PATIENT INFORMATION

Name: ______________________________ DOB: ______________ Gender: ☐ M ☐ F

Address: ______________________________ City: ______________ State: ____________ Zip: ____________

Phone: ______________________ Alt. Phone: ______________________ Email: ______________________________

Language : ☐ English ☐ Spanish ☐ Other: ______________________________ Height: ____________ Weight: ______________

STATEMENT OF MEDICAL NECESSITY

Weight: ______________ Height: ______________ Allergies: ____

TB/PPD Test given or intended to be given before start date? ☐ Yes ☐ No

Diagnosis Date: ____/____/______ **ICD-10 Code:** ______________ ☐ Rheumatoid Arthritis ☐ Psoriatic Arthritis

☐ Crohn's Disease ☐ Systemic Lupus Erythematosus ☐ Mod to Sev Plaque Psoriasis ☐ Osteoporosis ☐ Other: ______________________________

Tried & Failed Medications:

☐ Methotrexate Duration: __________________ Reason for Discontinuing: ______________________________

☐ ______________ Duration: __________________ Reason for Discontinuing: ______________________________

☐ ______________ Duration: __________________ Reason for Discontinuing: ______________________________

Forteo/Prolia: T-Score ______________________ Type: ______________________ Date: ______________________

Fracture History: Site ______________________ Date: ______________________

PRESCRIPTION INFORMATION

Medication	Dose & Strength	Directions	Qty	Refills
☐ **ACTEMRA®**	☐ 162mg Prefilled Syringe ☐	☐ Inject 162mg subcutaneously ☐ ONCE a week or ☐ every OTHER week. ☐ Infuse ______mg at ______________________________________. ☐ Others:	4 Week Supply	....
☐ **BENLYSTA®**	☐ 120mg Vials ☐ 400mg Vials ☐ 200 Autoinjector ☐ 200 Prefilled Syringe	☐ **Loading:** Infuse ______mg (10mg/kg) at weeks 0,2, and 4, then every 4 weeks thereafter. ☐ **Maintenance:** Infuse ______mg (10mg/kg) every 4 weeks. ☐ Inject 200mg subcutaneously once a week. ☐ Others:	4 Week Supply	....
☐ **CIMZIA®**	☐ 200x2 Prefilled Syringe ☐ 200x2 LYO Powder	☐ **Initial:** Inject 400mg subcutaneously at week 0,2 and 4. ☐ **Maintenance:** Inject 400mg subcutaneously once every 4 weeks OR ☐ Inject 200mg subcutaneously once every 2 weeks. ☐ Others:	4 Week Supply	....
☐ **COSENTYX®**	☐ 150mg Sensoready Pen ☐ 300mg Sensoready Pen ☐ 150mg Prefilled Syringe ☐ 300mg Prefilled Syringe	☐ Inject dose subcutaneously on week 0,1,2,3,4. ☐ Inject dose subcutaneously every 4 weeks. ☐ Others:	Loading Dose 4 Week Supply	None
☐ **ENBREL®**	☐ 50mg Sureclick ☐ 50mg Prefilled Syringe ☐ 25mg PFS or ☐ Vials	☐ Inject 50mg subcutaneously ONCE a week. ☐ Inject 25mg subcutaneously TWICE a week 72-96 hours apart. ☐ Others:	4 Week Supply	....
☐ **HUMIRA®** ☐ **HUMIRA CF®** (Citrate-free)	☐ 40mg Pen ☐ 40mg Prefilled Syringe	☐ Inject subcutaneously 40mg EVERY OTHER week. ☐ Inject subcutaneously 40mg ONCE a week. ☐ Others:	4 Week Supply	....
☐ **OTEZLA®**	☐ Starter Pack ☐ 30mg Tablets	☐ **Titration:** Take 1 tablet on day 1 then twice daily as directed. ☐ Take 1 tablet by mouth twice daily. ☐ Others:	1 Starter Pack 60	None ....
☐ **OLUMIANT®**	☐ 2mg Tablet	☐ Take 1 tablet (2mg) once daily with or without food. ☐ Others:	4 Week Supply	....
☐ **PROLIA®**	☐ 60mg Syringe	☐ Inject 60mg subcutaneously once every 6 months. ☐ Others:	4 Week Supply	....
☐ **SIMPONI ARIA®**	☐ 50mg Smartject ☐	☐ Inject 50mg subcutaneously ONCE a MONTH as directed. ☐ Infuse ________mg at weeks 0 and 4, then every 8 weeks thereafter. ☐ Others:	4 Week Supply	....
☐ **STELARA®**	☐ 45mg Prefilled Syringe	☐ Inject 45mg on day 0, then week 4, then every 12 weeks. ☐ Others:	4 Week Supply	....
☐ **XELJANZ®** ☐ **XELJANZ XR®**	☐ 5mg Tablets ☐ 11mg Tablets	☐ Xeljanz 1 tablet by mouth twice daily as directed. ☐ Xeljanz XR 1 tablet by mouth twice daily as directed. ☐ Others:	60 30	....
☐ **OTHER:** _________			....	....

Prescriber's Signature: ______________________________ ☐ **DAW (Dispense As Written) Date:** ____________________

Prescriber's Name: ______________________________ **Phone:** ____________________ **Fax:** ____________________

Prescriber's Address: ______________________________ **City:** ______________ **State:** ____________ **Zip:** ____________

NPI: ____________________ **DEA:** ______________ **Tax I.D:** ____________________ **Office Contact:** ____________________

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