Rheumatology Enrollment Form

INFUSE HEALTH

25329 Budde Road, Suite #104
Spring, TX 77380
Phone: 832-713-6119 . Fax: 281-809-6917

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	.....
□ **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:** _____