Rheumatology Enrollment Form

Date: ____________________ Needs by Date: ____________________
*Ship to: ☐ Patient ☐ Office ☐ Home Injection Training

Prescriber Information:

Prescriber Name: ____________________
State License #: ____________________ DEA # ____________________
Group or Hospital: ____________________
Address: ____________________
City, State, Zip ____________________
Phone: ____________________ Fax: ____________________ Office Contact: ____________________

Patient Information: (Complete the following patient info sheet and send in the demographic sheet)

Patient Name: ____________________
Address: ____________________
City, State, Zip ____________________
Home Phone: ____________________ Alternate Phone: ____________________
Patient SS # : ____________________ Date of Birth: ____________________
Allergies: ____________________

ICD 10:

INSURANCE INFORMATION: PLEASE FAX COPY OF INSURANCE CARD (Front & Back)

Diagnosis:

☐ L40.59 Psoriatic Arthritis
☐ M32.10 SLE
☐ M06.9 Rheumatoid Arthritis
☐ M45.0 Ankylosing Spondylitis
☐ Other ____________________

Prior (FAILED) Medications

Medications	Duration of Treatment / Reason for D/C
____________________	____________________
____________________	____________________

Comments: ____________________

Other Clinical Info / Comments:

General: Is patient also taking methotrexate?	☐ Yes	☐ No
TB/PPD Test given?	☐ Yes	☐ No
Does patient have a latex allergy?	☐ Yes	☐ No

Patient: WEIGHT __________ lbs. or ____________ kgs.
Comments: ____________________

PRESCRIPTION INFORMATION:

MEDICATION	DOSE / STRENGTH	DOSE / STRENGTHDIRECTIONS	QUANTITY	REFILLS
☐ Cimzia®	☐ 200mg/1ml PFS ☐ 200mg vial	☐ Induction Dose: Inject 400mg subcutaneously on day 1, at week 2, and at week 4 ☐ Maintenance Dose: Inject 200mg subcutaneously every OTHER week ☐ Maintenance Dose: Inject 400mg subcutaneously every 4 weeks ☐ Other ____________________		
☐ Enbrel ®	☐ 50mg/ml Sureclick Autoinjector ☐ 50mg/ml Prefilled Syringe ☐ 25mg Vial (inj. supplies incl) ☐ 25mg/0.5 ml PFS	☐ Inject 50mg SC ONCE a week ☐ ____________________ ☐ Inject 25mg SC TWICE a week	4 week supply	
☐ Humira ®	☐ 40mg/0.8ml PEN ☐ 40mg/0.8 Prefilled Syringe	☐ Inject 40mg SC every OTHER week ☐ Inject 40mg SC ONCE a week	4 week supply	
☐ Orencia®	☐ 250mg Vial ☐ 125mg Prefilled Syringe ☐ 125mg clickject	☐ Infuse ______ mg at weeks, 0, 2 and 4, then every 4 weeks thereafter ☐ Infuse ______ mg, ☐ Inject 125mg SC weekly ☐ Other	4 week supply ________	
☐ Otezla®	☐ 4 Week Starter Pack ☐ 30mg Tablet	☐ Follow package directions for 4 week titration ☐ Maintenance dose: 30mg by mouth twice daily		
☐ Otrexup®	☐ 10mg Prefilled Syringe ☐ 12.5mg Prefilled Syringe ☐ 15mg Prefilled Syringe ☐ 17.5mg Prefilled Syringe ☐ 20mg Prefilled Syringe ☐ 22.5mg Prefilled Syringe ☐ 25mg Prefilled Syringe	☐ Inject 10mg SC once Weekly ☐ Inject 12.5mg SC once Weekly ☐ Inject 15mg SC once Weekly ☐ Inject 17.5mg SC once Weekly ☐ Inject 20mg SC once Weekly ☐ Inject 22.5mg SC once Weekly ☐ Inject 25mg SC once Weekly		
☐ Remicade®	☐ 100mg Vial ☐ 5mg/kg ☐ ______mg/kg	☐ IV at 0, 2 and 6 weeks (induction) ☐ IV every 8 weeks (maintenance) ☐ IV every _______ weeks	________ (# of vials)	
☐ Rituxan®	☐ 100mg/10ml Vial ☐ 500mg/50ml Vial	☐ ____________________	________ (# of vials)	
☐ Simponi® (indicated for RA, PsA and AS)	☐ 50mg/0.5ml SMartJect PEN ☐ 50mg/0.5ml Prefilled Syringe ☐ Aria 50mg/4ml vial	☐ Inject 50mg SC once monthly ☐ Induction Dose: 2mg/kg IV week 0 and week4 ☐ Maintenance Dose: 2mg/kg IV every 8 weeks	1 month supply ________ (# of vials)	
☐ Xeljanz®	☐ 5mg Tablet ☐ 11mg ER Tablet	☐ 5mg by mouth twice daily ☐ 11mg ER by mouth twice daily		

____________________ (Prescriber Signature) ☐ Dispense as Written ____________________ Date

* All Patients automatically enrolled in appropriate Mfg./Copay programs

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FAX REFERRAL TO: 718-360-9655
or call 718-556-0942