



Rheumatology Infusion Enrollment Form R-Z

Date: _____

Patient Data

Patient Name: _____ Birthdate: _____ Sex: Male Female Height: _____ Weight: _____ lbs kg
 SSN #: XXX-XX-____ Known Allergies: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Home Phone: _____ Cell Phone: _____ Primary Language: _____
 Alternate Caregiver Name: _____ Phone of Caregiver: _____

Ins. Data

Primary Insurance: _____ Secondary Insurance: _____
 Policy: _____ Group#: _____ Policy: _____ Group#: _____

Clinical Information

To expedite prior authorization, please attach PPD results, lab results, clinical office notes, and past treatment history.

Diagnosis : M06.9 Rheumatoid Arthritis M31.3 Granulomatosis with Polyangiitis M31.7 Microscopic Polyangiitis M32.9 Systemic Lupus
M32.14 Lupus Nephritis L40.52 Psoriatic Arthritis M45.9 Ankylosing Spondylitis Other: _____
 Does patient have a latex allergy? Yes No Has patient been tested for Hepatitis B? Yes No If positive, has treatment been initiated? Yes No
 Has patient received PPD (tuberculosis) skin test: Yes No Date: _____ Results: Positive Negative
 Has patient previously been treated for this condition: Yes No Joints Affected: _____
 If yes, medication/therapy failed (length of therapy): _____

Prescription

Medication	Strength	Directions	Quantity	Refills
<input type="checkbox"/> Remicade® <input type="checkbox"/> Avsola™ <i>infliximab biosimilar</i> <input type="checkbox"/> Inflectra® <i>infliximab biosimilar</i>	100mg SDV vial	<i>Rheumatoid Arthritis</i> <input type="checkbox"/> Induction: Infuse 3mg/kg intravenously at weeks 0, 2, and 6	Quantity Sufficient x3 doses	0 refills
		<input type="checkbox"/> Maintenance: Infuse 3mg/kg intravenously every 8 weeks Patient weight _____kg	Quantity Sufficient for 8 weeks	
		<i>Ankylosing Spondylitis</i> <input type="checkbox"/> Induction: Infuse 5mg/kg intravenously at weeks 0, 2, and 6	Quantity Sufficient x3 doses	0 refills
		<input type="checkbox"/> Maintenance: Infuse 5mg/kg intravenously every 6 weeks Patient weight _____kg	Quantity Sufficient for 6 weeks	
		<i>Psoriatic Arthritis</i> <input type="checkbox"/> Induction: Infuse 5mg/kg intravenously at weeks 0, 2, and 6	Quantity Sufficient x3 doses	0 refills
		<input type="checkbox"/> Maintenance: Infuse 5mg/kg intravenously every 8 weeks Patient weight _____kg	Quantity Sufficient for 8 weeks	
<input type="checkbox"/> Rituxan® <input type="checkbox"/> Ruxience <i>rituximab biosimilar</i> <input type="checkbox"/> Truxima® <i>rituximab biosimilar</i>	500mg/50ml vial	<i>Rheumatoid Arthritis</i> <input type="checkbox"/> Infuse two 1000mg doses intravenously 2 weeks apart. Repeat every _____ weeks (no sooner than every 16 weeks)	#4 vials	
		<i>Granulomatosis with Polyangiitis & Microscopic Polyangiitis (Rituxan & Truxima ONLY)</i> <input type="checkbox"/> Induction: Infuse 375mg/m ² intravenously once weekly for 4 weeks Patient weight _____kg Patient height _____inches	Quantity Sufficient x4 doses	0 refills
		<input type="checkbox"/> First maintenance dose: Infuse two 500mg doses intravenously 2 weeks apart, begin maintenance in 6 months	#2 vials	0 refills
		<input type="checkbox"/> Final maintenance dose: Infuse 500mg intravenously once every 6 months	#1 vial	
<input type="checkbox"/> Simponi Aria®	50mg/4ml vial	<input type="checkbox"/> Induction: Infuse 2mg/kg intravenously at weeks 0 and 4	Quantity Sufficient x2 doses	0 refills
		<input type="checkbox"/> Maintenance: Infuse 2mg/kg intravenously every 8 weeks Patient weight _____kg	Quantity Sufficient for 8 weeks	

Is patient new to this therapy: YES NO | Ship to: Office Other | Need by Date: _____

Prescriber Data

Prescriber Name: _____ DEA#: _____ NPI: _____
 Practice Name: _____ Contact: _____
 Address: _____ Phone: _____ Fax: _____
 City: _____ State: _____ Zip: _____ Key Contact#: _____

My signature below authorizes Value Specialty Pharmacy staff to act as my authorized agent to complete the insurance prior authorization process for my patient listed above. My authorization shall include any required signatures by Value Specialty Pharmacists on my behalf to facilitate this process and acknowledge their authorized access to necessary healthcare data to complete said process.

Physician Signature: _____ Date: _____

This prescription will be filled generically unless prescriber writes "DAW" in the box to the right.

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