# Rheumatology Enrollment Form O-Z

RESTORE Rx SPECIALTY PHARMACY

Date: _____

## Patient Data

Patient Name: _____ Birthdate: _____
SSN #: XXX-XX-_____
Address: _____
Home Phone: _____ Cell Phone: _____
Alternate Caregiver Name: _____

Sex: ☐ Male ☐ Female Height: _____ Weight: _____ lbs ☐ kg ☐
Known Allergies: _____
City: _____ State: _____ Zip: _____
Primary Language: _____
Phone of Caregiver: _____

## Ins. Data

Primary Insurance: _____
Policy: _____ Group#: _____

Secondary Insurance: _____
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 ☐M33.00 Juvenille Rheumatoid Arthritis ☐L40.52 Psoriatic Arthritis ☐M45.9 Ankylosing Spondylitis ☐M32.9 Systemic Lupus ☐M32.14 Lupus Nephritis ☐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):

Injection training needed: ☐Yes ☐No

_____

_____

## Prescription

| Medication | Strength | Directions | Quantity | Refills |
|---|---|---|---|---|
| ☐ Olumiant® | 2mg tablet | Take 1 tablet orally once daily | #30 | |
| ☐ Orencia® | ☐ 125mg/ml PFS<br>☐ 125mg/ml ClickJect™ autoinjector | Inject 125mg SQ every 7 days | #4 | |
| ☐ Otezla® | ☐ Titration Starter Pack | Induction: Use as directed per titration pack instructions | #1 pack | 0 refills |
| | ☐ 30mg tablet | Maintenance: Take 1 tablet orally twice daily | #60 | |
| ☐ Otrexup® | ☐ 10mg/0.4ml autoinjector<br>☐ 12.5mg/0.4ml autoinjector<br>☐ 15mg/0.4ml autoinjector<br>☐ 17.5mg/0.4ml autoinjector<br>☐ 20mg/0.4ml autoinjector<br>☐ 22.5mg/0.4ml autoinjector<br>☐ 25mg/0.4ml autoinjector | Inject 1 pen SQ once weekly | #4 | |
| ☐ Rinvoq™ | 15mg tablet | Take 1 tablet orally once daily | #30 | |
| ☐ Simponi® | ☐ 50mg/0.5ml PFS<br>☐ 50mg/0.5ml SmartJect autoinjector | Inject 50mg SQ once every 28 days | #1 | |
| ☐ Stelara® | ☐ 45mg/0.5ml PFS<br>☐ 90mg/1ml PFS | *Patient weight 100kg or less*<br>☐ Induction: Inject 45mg SQ at weeks 0 and 4 | #2 | 0 refills |
| | | ☐ Maintenance: Inject 45mg SQ every 12 weeks<br>Patient weight _____kg | #1 | |
| | | *Patient weight greater than 100kg*<br>☐ Induction: Inject 90mg SQ at weeks 0 and 4 | #2 | 0 refills |
| | | ☐ Maintenance: Inject 90mg SQ every 12 weeks<br>Patient weight _____kg | #1 | |
| ☐ Taltz® | ☐ 80mg/ml PFS<br>☐ 80mg/ml autoinjector | ☐ Induction: Inject 160mg (2 injections) SQ at week 0 | #2 | 0 refills |
| | | ☐ Maintenance: Inject 80mg SQ every 4 weeks | #1 | |
| ☐ Xeljanz® | 5mg tablet | Take 1 tablet orally twice daily | #60 | |
| ☐ Xeljanz XR® | 11mg tablet | Take 1 tablet orally once daily | #30 | |

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

## Prescriber Data

Prescriber Name: _____
Practice Name: _____
Address: _____
City: _____ State: _____ Zip: _____

DEA#: _____ NPI: _____
Contact: _____ Preferred Method: ☐ Phone ☐ Fax ☐ Email
Phone: _____ Fax: _____
Email: _____

My signature below authorizes Restore Rx, Inc. 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 Restore Rx, Inc. 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. ☐