Rheumatology Enrollment Form A-K

RESTORE Rx SPECIALTY PHARMACY

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
☐ Actemra®	☐ 162mg/0.9ml PFS ☐ 162mg/0.9ml ActPen	*Patients less than 100kg* ☐ Inject 162mg SQ every 14 days	#2	
		Patients 100kg or above ☐ Inject 162mg SQ every 7 days	#4	
☐ Benlysta	☐ 200mg/ml PFS ☐ 200mg/ml autoinjector	Inject 200mg SQ once weekly	#4	
☐ Cimzia®	☐ 200mg/ml PFS ☐ 200mg/ml vial	☐ Induction: Inject 400mg SQ at weeks 0, 2, and 4	#6	0 refills
		☐ Maintenance: Inject 400mg SQ every 4 weeks ☐ Maintenance: Inject 200mg SQ every 14 days	#2	
☐ Cosentyx®	☐ 150mg/ml PFS ☐ 150mg/ml pen	☐ Induction: Inject 150mg SQ at weeks 0, 1, 2, 3, and 4	#5	0 refills
		☐ Maintenance: Inject 150mg SQ every 4 weeks ☐ Maintenance: Inject 300mg (two injections) SQ every 4 weeks		
☐ Enbrel®	☐ 50mg/ml PFS ☐ 50mg/ml SureClick™ Autoinjector ☐ 50mg/ml mini cartridge *AutoTouch device available only through RxCrossroads* ☐ 25mg/0.5ml PFS ☐ 25mg/0.5ml vial	☐ Inject 25mg SQ every 7 days ☐ Inject 50mg SQ every 7 days	#4	
☐ Humira® *Citrate Free*	☐ 40mg/0.4ml PFS ☐ 40mg/0.4ml pen ☐ 80mg/0.8ml PFS ☐ 80mg/0.8ml pen	☐ Inject 40mg SQ every 14 days ☐ Inject 80mg SQ every 14 days	#2	
☐ Kevzara®	☐ 150mg/1.14ml PFS ☐ 150mg/1.14ml pen	Inject 150mg SQ every 14 days	#2	
	☐ 200mg/1.14ml PFS ☐ 200mg/1.14ml pen	Inject 200mg SQ every 14 days	#2	

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. ☐