Rheumatology Infusion Enrollment Form A-O

RESTORE Rx SPECIALTY PHARMACY

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
☐ Actemra®	☐ 80mg/4ml vial ☐ 200mg/10ml vial ☐ 400mg/20ml vial	*Rheumatoid Arthritis* ☐ Infuse 4mg/kg intravenously every 4 weeks Patient weight _____kg	Quantity Sufficient for 1 month	
		☐ Infuse 8mg/kg intravenously every 4 weeks Patient weight _____kg	Quantity Sufficient for 1 month	
☐ Orencia®	250mg vial (lyophilized powder)	*Patient weight less than 60kg* ☐ Induction: Infuse 500mg intravenously at weeks 0, 2, and 4	#6 vials	0 refills
		☐ Maintenance: Infuse 500mg intravenously every 4 weeks Patient weight _____kg	#2 vials	
		Patient weight 60-100kg ☐ Induction: Infuse 750mg intravenously at weeks 0, 2, and 4	#9 vials	0 refills
		☐ Maintenance: Infuse 750mg intravenously every 4 weeks Patient weight _____kg	#3 vials	
		Patient weight greater than 100kg ☐ Induction: Infuse 1000mg intravenously at weeks 0, 2, and 4	#12 vials	0 refills
		☐ Maintenance: Infuse 1000mg intravenously every 4 weeks Patient weight _____kg	#4 vials	

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

Prescriber Data

Prescriber Name: _____
DEA#: _____ NPI: _____
Practice Name: _____
Contact: _____ Preferred Method: ☐ Phone ☐ Fax ☐ Email
Address: _____
Phone: _____ Fax: _____
City: _____ State: _____ Zip: _____
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. ☐