Rheumatology Infusion Enrollment Form R-Z

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
☐ Remicade® ☐ Avsola™ *infliximab biosimilar* ☐ Inflectra® *infliximab biosimilar* ☐ Renflexis *infliximab biosimilar*	100mg SDV vial	*Rheumatoid Arthritis* ☐ Induction: Infuse 3mg/kg intravenously at weeks 0, 2, and 6	Quantity Sufficient x3 doses	0 refills
		☐ Maintenance: Infuse 3mg/kg intravenously every 8 weeks Patient weight _____kg	Quantity Sufficient for 8 weeks	
		Ankylosing Spondylitis ☐ Induction: Infuse 5mg/kg intravenously at weeks 0, 2, and 6	Quantity Sufficient x3 doses	0 refills
		☐ Maintenance: Infuse 5mg/kg intravenously every 6 weeks Patient weight _____kg	Quantity Sufficient for 6 weeks	
		Psoriatic Arthritis ☐ Induction: Infuse 5mg/kg intravenously at weeks 0, 2, and 6	Quantity Sufficient x3 doses	0 refills
		☐ Maintenance: Infuse 5mg/kg intravenously every 8 weeks Patient weight _____kg	Quantity Sufficient for 8 weeks	
☐ Rituxan® ☐ Ruxience *rituximab biosimilar* ☐ Truxima® *rituximab biosimilar*	500mg/50ml vial	*Rheumatoid Arthritis* ☐ Infuse two 1000mg doses intravenously 2 weeks apart. Repeat every _____ weeks (no sooner than every 16 weeks)	#4 vials	
		Granulomatosis with Polyangiitis & Miscroscopic Polyangiitis (Rituxan & Truxima ONLY) ☐ Induction: Infuse 375mg/m² intravenously once weekly for 4 weeks Patient weight _____kg Patient height _____inches	Quantity Sufficient x4 doses	0 refills
		☐ First maintenance dose: Infuse two 500mg doses intravenously 2 weeks apart, begin maintenance in 6 months	#2 vials	0 refills
		☐ Final maintenance dose: Infuse 500mg intravenously once every 6 months	#1 vial	
☐ Simponi Aria®	50mg/4ml vial	☐ Induction: Infuse 2mg/kg intravenously at weeks 0 and 4	Quantity Sufficient x2 doses	0 refills
		☐ 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:** ☐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.