



# RHEUMATOLOGY ENROLLMENT FORM

PLEASE FAX TO: 207-899-0968

PHONE: 207-899-0939

PATIENT INFORMATION			
Patient Name:		Date of Birth: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Address:			
Phone:		Alternate Phone:	
Height:	Weight:	Allergies:	Allergy to latex? <input type="checkbox"/> Yes <input type="checkbox"/> No

DIAGNOSIS	
Date of diagnosis: _____	
<input type="checkbox"/> Psoriatic arthritis (L40.52) <input type="checkbox"/> Ankylosing spondylitis (M45.9) <input type="checkbox"/> Rheumatoid arthritis (M05.____) <input type="checkbox"/> Osteoarthritis (M19.90) <input type="checkbox"/> Polyarticular juvenile RA (M08.00) <input type="checkbox"/> Osteoporosis (M81.0)	<input type="checkbox"/> Uveitis: <input type="checkbox"/> Posterior (H_____) <input type="checkbox"/> NI Intermediate (H_____) <input type="checkbox"/> Panuveitis (H_____) <input type="checkbox"/> Giant cell arteritis (M31.____) <input type="checkbox"/> Other: _____ (ICD-10)

CLINICAL INFORMATION	
Date of TB test: _____ Results: <input type="checkbox"/> negative <input type="checkbox"/> pending	Previously failed DMARDS: _____
Treatment History: <input type="checkbox"/> New start <input type="checkbox"/> Restart <input type="checkbox"/> Continuing therapy <input type="checkbox"/> Drug change	Previously failed biologics: _____
Current therapy: _____ Stop before starting new therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No	Withhold for how long before starting: _____

DRUG	FORMULATION	DIRECTIONS	QTY	RF
<input type="checkbox"/> ACTEMRA	<input type="checkbox"/> 162 mg PFS <input type="checkbox"/> 162 mg ACTPen	<input type="checkbox"/> 162 mg SQ every other week <input type="checkbox"/> 162 mg SQ weekly (>100 kg or diagnosis of GCA)		
<input type="checkbox"/> CIMZIA	<input type="checkbox"/> 200 mg PFS <input type="checkbox"/> 200 mg vials	<input type="checkbox"/> Loading dose: 400 mg (two 200 mg injections) SQ weeks 0, 2, and 4, then begin maintenance Maintenance dose: <input type="checkbox"/> 400 mg (two 200 mg injections) SQ every 4 weeks <input type="checkbox"/> 200 mg SQ every 2 weeks	6	0
<input type="checkbox"/> COSENTYX	<input type="checkbox"/> 150 mg PFS <input type="checkbox"/> 150 mg Sensoready Pen	Loading dose: <input type="checkbox"/> 150 mg SQ at weeks 0, 1, 2, 3 and 4, then begin maintenance <input type="checkbox"/> 300mg (two 150mg injections) SQ at weeks 0, 1, 2, 3 and 4, then maintenance Maintenance dose: <input type="checkbox"/> 150 mg SQ every 4 weeks <input type="checkbox"/> 300mg (two 150 mg injections) SQ every 4 weeks	QS	0
<input type="checkbox"/> ENBREL	<input type="checkbox"/> 25 mg multi-use vial <input type="checkbox"/> 25 mg PFS <input type="checkbox"/> 50 mg PFS <input type="checkbox"/> 50 mg SureClick Pen <input type="checkbox"/> 50 mg Mini Cartridges	<input type="checkbox"/> 25 mg SQ twice weekly (72 - 96 hours apart) <input type="checkbox"/> 50 mg SQ weekly <i>*Office must supply autoinjector device for Enbrel Mini Device</i>		
<input type="checkbox"/> HUMIRA <input type="checkbox"/> HUMIRA Citrate Free (lower volume)	<input type="checkbox"/> Humira Uveitis loading dose Pen kit <input type="checkbox"/> 10 mg PFS <input type="checkbox"/> 20 mg PFS <input type="checkbox"/> 40 mg PFS <input type="checkbox"/> 40 mg Pen	<input type="checkbox"/> Starter pack uveitis: 80 mg SQ day 1 then 40 mg SQ on day 8, followed by 40 mg every other week <input type="checkbox"/> <15 kg: 10 mg SQ every 14 days (every OTHER week) <input type="checkbox"/> <30 kg: 20 mg SQ every 14 days (every OTHER week) <input type="checkbox"/> 40 mg SQ every 14 days (every OTHER week) <input type="checkbox"/> 40 mg SQ every week		0
<input type="checkbox"/> KEVZARA	200 mg PFS	200 mg SQ every other week		
<input type="checkbox"/> OLUMIANT	2 mg tablet	2 mg by mouth once daily		
<input type="checkbox"/> ORENCIA	<input type="checkbox"/> 125 mg PFS <input type="checkbox"/> 125 mg Clickjet	125 mg SQ weekly		
<input type="checkbox"/> OTEZLA	30 mg tablet	<input type="checkbox"/> Titration pack: Take as directed on pack <i>or</i> Given by office on ____/____/____ <input type="checkbox"/> Maintenance dose: Take 1 tablet PO twice daily	1	0
<input type="checkbox"/> OTREXUP	Autoinjector	<input type="checkbox"/> 10mg <input type="checkbox"/> 12.5mg <input type="checkbox"/> 15mg <input type="checkbox"/> 17.5mg <input type="checkbox"/> 20mg <input type="checkbox"/> 22.5mg <input type="checkbox"/> 25 mg SQ weekly		
<input type="checkbox"/> RASUVO	Autoinjector	<input type="checkbox"/> 7.5 <input type="checkbox"/> 10 <input type="checkbox"/> 12.5 <input type="checkbox"/> 15 <input type="checkbox"/> 17.5 <input type="checkbox"/> 20 <input type="checkbox"/> 22.5 <input type="checkbox"/> 25 <input type="checkbox"/> 27.5 <input type="checkbox"/> 30 mg SQ weekly		
<input type="checkbox"/> RINVOQ	15 mg XR tablet	15 mg by mouth ONCE daily		
<input type="checkbox"/> SIMPONI	<input type="checkbox"/> 50 mg PFS <input type="checkbox"/> 50 mg Smartject Pen	50 mg SQ once monthly		
<input type="checkbox"/> STELARA	<input type="checkbox"/> 45 mg PFS (<100 kg) <input type="checkbox"/> 90 mg PFS (>100 kg)	<input type="checkbox"/> Loading dose: One PFS SQ initially, one on week 4, then once every 12 weeks <input type="checkbox"/> Maintenance dose: One PFS SQ every 12 weeks		0
<input type="checkbox"/> TALTZ	<input type="checkbox"/> 80 mg PFS <input type="checkbox"/> 80 mg Pen	<input type="checkbox"/> Loading dose: 160 mg ( two 80 mg injections) SQ once followed by 80mg every 4 weeks <input type="checkbox"/> Maintenance dose: 80 mg SQ every 4 weeks	2	0
<input type="checkbox"/> XELJANZ	<input type="checkbox"/> 5 mg tablet <input type="checkbox"/> 11 mg XR tablet	<input type="checkbox"/> 5 mg by mouth TWICE daily <i>alternate dosing:</i> <input type="checkbox"/> 5 mg by mouth ONCE daily <input type="checkbox"/> 11 mg by mouth ONCE daily		
<input type="checkbox"/> OTHER:				

Patient is ready to start treatment, contact patient for delivery    
  Ship all orders to office    
  Ship first order to office, subsequent orders to patient

PRESCRIBER SIGNATURE:		DATE:	
PHYSICIAN NAME:	DEA #:	NPI #:	STATE LICENSE #:
PRACTICE NAME:	ADDRESS:	CITY, STATE:	ZIP:
PHONE #:	FAX:	OFFICE CONTACT:	

*Your signature authorizes the pharmacy to act on your behalf to obtain prior authorization for the prescribed medications. We will also pursue available copay and financial assistance on behalf of your patients. Following prior authorization, if insurance dictates the prescription be filled at a specific pharmacy ABD will forward the prescription to that pharmacy and the office and patient will be notified.*