RHEUMATOLOGY ENROLLMENT FORM

PLEASE FAX TO: 207-899-0968
PHONE: 207-899-0939

PATIENT INFORMATION

Patient Name: Date of Birth: ☐ Male ☐ Female

Address:

Phone: Alternate Phone:

Height: Weight: Allergies: Allergy to latex? ☐ Yes ☐ No

DIAGNOSIS

Date of diagnosis: _____

☐ Psoriatic arthritis (L40.52) ☐ Ankylosing spondylitis (M45.9)
☐ Rheumatoid arthritis (M05.____) ☐ Osteoarthritis (M19.90)
☐ Polyarticular juvenile RA (M08.00) ☐ Osteoporosis (M81.0)

☐ Uveitis: ☐ Posterior (H_____) ☐ NI Intermediate (H_____)
☐ Panuveitis (H_____)
☐ Giant cell arteritis (M31.____)
☐ Other: _____ (ICD-10)

CLINICAL INFORMATION

Date of TB test: _____ Results: ☐ negative ☐ pending Previously failed DMARDS: _____
Treatment History: ☐ New start ☐ Restart ☐ Continuing therapy ☐ Drug change Previously failed biologics: _____
Current therapy: _____ Stop before starting new therapy? ☐ Yes ☐ No Withhold for how long before starting: _____

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