Faxed prescription will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy. Prescribers are reminded patients may choose any pharmacy of their choice.

Rheumatology Enrollment Form

1403 Highway 6 Suite 700A, Sugar Land, TX 77478 Phone: 832.944.6112 Fax: 832.944.6116

Patient Information

Patient Name: _____ Birthdate: _____ Sex: ____ Male ____ Female Height: ____ Weight: ____ lbs. ____ kg.

Soc. Sec. #: _____ Preferred Phone: _____ Known Allergies: _____

Address: _____ City: _____ State: _____ Zip: _____

Alternate Caregiver Name: _____ Preferred Phone: _____

Insurance Information: Please fax FRONT and BACK copy of ALL Insurance cards (prescription and medical)

Prescriber Information

Name: _____ DEA#: _____ NPI#: _____ Tax ID#: _____

Address: _____ Phone: (_____) _____ - _____ Fax: (_____) _____ - _____

City: _____ State: _____ Zip: _____ Key Contact: _____ Phone: (_____) _____ - _____

Diagnosis/Clinical Information

Please FAX recent clinical notes, Labs, Tests, with the prescription to expidite the Prior Authorization

Diagnosis: _____ ICD-9: _____ Genotype: _____ Subtype: _____ Viral Load: _____

NS Q80k Polymorphism Results: _____ Prior Treatment Date: _____

Response Status: __ Naive __ Null __ Partial __ Relapse Compensated Cirrchosis: __ Yes __ No Fibrosis Score: _____

Prescription Information

Medication	Dose/Strength	Sig	Qty.	Refills
__ Actemra	__ 80mg vials __ 200mg vials __ 400mg vials	__ Infuse __mg OR 4mg/kg IV over 1 hour every 4 weeks (Quantity: q.s. 1 dose) __ Infuse __mg OR 8mg/kg IV over 1 hour every 4 weeks (Quantity: q.s. 1 dose)		
__ Benlysta	__ 120 mg 5ml vials __ 400 mg 20 ml vials __ 250 ml NS IV bag	__ Initial: Infuse __mg OR 10 mg/kg IV over 1 hour every 2 weeks for 3 doses (Quantity: q.s. 3 doses) __ Maintenance: Infuse __mg OR 10mg/kg IV over 1 hour every 4 weeks (Quantity: 1 dose)		
__ Boniva	__ 3mg / 3 mL injection	__ Inject 3mg / mL once every 3 months		
__ Kyrstexxa	__ 8mg/mL vials	__ Infuse IV 8mg every 2 weeks over no less than 120 minutes (Quantity: 2 doses)		
__ Orencia	__ 250mg vials	__ Initial: Infuse __mg IV over 1 hour at weeks 0, 2 and 4 (Quantity: q.s. 3 doses) __ Maintenance: Infuse __mg IV over 1 hour every 4 weeks (Quantity: 1 dose)		
__ Remicade	__ 100 mg vial __ 250ml NS IV bag	__ Initial: Infuse ____mg OR ____mg/kg via IV at weeks 0, 2, and 6 (Quantity: q.s. 3 doses) __ Maintenance: Infuse ____mg OR ____mg/kg via IV every ____ weeks thereafter (Quantity: 1 dose)		
__ Rituxan	__ 500mg / 50mL vial	__ Infuse 1000mg IV on week 0 and week 2. Repeat every ____ months thereafter (Quantity: 1 dose)		
__ Simponi Aria	__ 50mg vials	__ Initial: Infuse 2mg/kg over 30 minutes at weeks 0 and 4 (Quantity: 2 doses) __ Maintenance: Infuse 2 mg/kg over 30 minutes every 8 weeks thereafter (Quantity: 1 dose)		
__ Cimzia	__ 200mg / 1mL prefilled syringe __ 200mg vial Maint. Dose: Inject	__Infusion Dose: Inject 400mg subcutaneously on day 1 and at week 2 __Maint. Dose: Inject 200mg Subcutaneously every other week, 400mg subcutaneously every 4 weeks __Other: _____		
__ Enbrel*	__ 50mg / mL Sureclick™ Autoinjector __ 50mg / mL Prefilled Syringe __ 25mg / 0.5mL Prefilled Syringe __ 25mg vial	__ Inject 50mg subcutaneously once a week __ Inject 25mg subcutaneously twice a week (72-96 hours apart) __ Other: _____		
__ Forteo	__ 600ug / 2.4 mL Delivery Device	__ Inject 20ug (0.08mL) Subcutaneously once daily		
__ Humira*	__ 40mg / 0.8mL PenInject __ 40mg / 0.8mL Perfilled Syringe __ 20mg / 0.4mL Prefilled Syringe	__ 40mg subcutaneously every other week __ Inject 20mg subcutaneously every other week __ Other: _____		
__ Kineret	__ 40mg / 0.8mL PenInject	__ Inject 100mg (one syringe) SC once a day		
__ Prolia	__ 60mg / mL	__ Inject 60mg / mL subcutaneously once every 6 months		
__ Reclast	__ 5g / 100mL	__ 5mg / 100mL once every year		
__ Stelara	__ 45mg Prefilled Syringe __ 90mg Prefilled Syringe	__ Inject 45mg SQ at weeks 0, 4 and then every 12 weeks __ Inject 90mg SQ at weeks 0, 4 and then every 12 weeks		
__ Simponi	__ 50mg / 0.5mL Prefilled SmartJect Autoinject. __ 50mg / 0.5mL Prefilled Syringe	__ Inject 50mg (0.5mL) subcutaneously once a month __ Other: _____		
__ Otezla	__ 10mg	__ Take 10mg PO qd on day 1, and increasing by 10mg daily until taking 30mg BID thereafter		
__ Xeljanz	__ 5mg	__ Take 5mg PO twice a day		
__ Tymlos	__ 80mcg/1.56ml pen	__ Inject 80 mcg sq qd, 30 days		

Date Medication Needed: ____/____/_____ Ship To: ____ Patient's Home _____ Prescriber's Office _____ Pick-up (store location): _____ Injection Training by Pharmacy

Patient Support Programs: Please sign and date below to enroll in the pharmaceutical company assisted patient support program

Patient Signature: **Date:**

Prescriber Signature: Prescriber, please sign and date below

Dispense as written **Date:** **Substitution Permissable** **Date**

# of Prescriptions: _____