RESTORE Rx SPECIALTY PHARMACY — Rheumatology Enrollment Form A-N

Date: _____

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: _____
Authorized Contact: _____
Contact's Phone: _____

Ins. Data

Primary Insurance: _____
Secondary Insurance: _____
ID: _____ Group#: _____
ID: _____ 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 ☐ M33.00 Juvenile Rheumatoid Arthritis ☐ L40.52 Psoriatic Arthritis ☐ M45.9 Ankylosing Spondylitis

☐ Other: _____ **Does patient have a latex allergy:** ☐Yes ☐No

Has patient received PDD (tuberculosis) skin test? ☐Yes ☐No Date: _____ Results: ☐Positive ☐Negative

Has patient been tested for Hepatitis B? ☐Yes ☐No **If positive, has treatment been initiated?** ☐Yes ☐No

Has patient previously been treated for this condition? ☐Yes ☐No **Joints Affected:** _____

If yes, medication/therapy failed (length of therapy): **Injection training needed?** ☐Yes ☐No

_____

_____

Prescription

Medication	Strength	Directions	Quantity	Refills
☐ Actemra®	162mg/0.9ml PFS	☐ Inject 162mg SQ every 7 days ☐ Inject 162mg SQ every 14 days		
☐ Cimzia®	☐ 200mg/ml PFS ☐ 200mg/ml vial	☐ Induction: Inject 400mg SQ at weeks 0, 2, and 4	#3	0 refills
		☐ Maintenance: Inject 400mg SQ every 4 weeks ☐ Maintenance: Inject 200mg SQ every 14 days		
☐ Cosentyx®	☐ 150mg pen ☐ 150mg PFS	☐ Induction: Inject 150mg SQ at weeks 0, 1, 2, 3, and 4	#5	0 refills
		☐ Maintenance: Inject 150mg SQ every 4 weeks ☐ Maintenance: Inject 300mg (two injections) SQ every 4 weeks		
☐ Enbrel®	☐ 50mg/ml PFS ☐ 50mg/ml SureClick™ Autoinjector ☐ 25mg/0.5ml PFS ☐ 25mg/0.5ml vial	☐ Inject 50mg SQ every 7 days ☐ Inject per weight based dosing _____ Weight _____ lb/kg Height _____ in/cm		
☐ Enbrel® Mini *AutoTouch™ device available only through RxCrossroads*	50mg/ml cartridge	Inject 50mg SQ every 7 days	#4	
☐ Humira®	☐ 40mg/0.8ml pen ☐ 40mg/0.8ml PFS	Inject 40 mg SQ every 14 days	#2	
☐ Humira® *Citrate Free*	☐ 40mg/0.4ml pen ☐ 40mg/0.4ml PFS	Inject 40 mg SQ every 14 days	#2	
☐ Kevzara®	☐ 150mg/1.14ml pen ☐ 150mg/1.14ml PFS ☐ 200mg/1.14ml pen ☐ 200mg/1.14ml PFS	☐ Inject 150mg SQ once every 14 days ☐ Inject 200mg SQ once every 14 days	#2	

Is patient new to this therapy? ☐ YES ☐ NO | **Ship to:** ☐ Patient ☐ Office ☐ Other | **Desired Start 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.