Rheumatology Enrollment Form O-Z

RESTORE Rx SPECIALTY PHARMACY

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
☐ Olumiant®	2mg tablet	Take 1 tablet orally once daily	#30	
☐ Orencia®	☐ 125mg/ml syringe ☐ 125mg/ml Clickjet™ autoinjector ☐ 250mg via (lyophilized powder)	☐ Inject 125mg SQ every 7 days	#4	
		☐ Infuse per weight based dosing _____ Weight _____lb/kg Height _____in/cm		
☐ Otezla®	☐ Titration Starter Pack	Day 1: 10mg in the morning Day 2: 10mg in the morning and in the evening Day 3: 10mg in the morning and 20mg in the evening Day 4: 20mg in the morning and in the evening Day 5: 20mg in the morning and 30mg in the evening Day 6 and thereafter: 30mg twice daily	1 pack	0 refills
	☐ 30mg tablet	☐ Maintenance: 30mg twice daily		
☐ Otrexup®	☐ 10mg/0.4ml autoinjector ☐ 15mg/0.4ml autoinjector ☐ 20mg/0.4mg/ml autoinjector ☐ 25mg/0.4mg/ml autoinjector	Inject _____mg via autoinjector SQ every 7 days		
☐ Rituxan®	☐ 100mg/10ml vial ☐ 500mg/50ml vial	Infuse _____mg intravenously once every _____weeks		
☐ Simponi®	☐ 50mg/0.5ml syringe ☐ 50mg/0.5ml autoinjector	Inject 50mg SQ once every 28 days	#1	
☐ Stelara®	☐ 45mg/0.5ml PFS (<100kg) ☐ 90mg/ml PFS (>100kg)	☐ Induction: Inject _____mg SQ at days 0 and 28	#2	0 refills
		☐ Maintenance: Inject _____mg SQ every 84 days (12 weeks)	#1	
☐ Taltz®	☐ 80mg/ml autoinjector ☐ 80mg/ml PFS	☐ Induction: Inject 160mg (2 injections) SQ at week 0	#2	0 refills
		☐ Maintenance: Inject 80mg SQ every 4 weeks	#1	
☐ Xeljanz®	5mg tablet	Take 1 tablet orally twice daily	#60	
☐ Xeljanz® XR	11mg tablet	Take 1 tablet orally once daily	#30	

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.