Rheumatology Enrollment Form (A-H)

Phone: 602-971-6950 / 877-971-3001
Fax: 877-552-5698

An AleraCare Company AleraCare A Healthcare Solutions Company

Prescriber Information

Patients must bring an original prescription to the pharmacy. Faxed prescriptions will only be accepted from a prescribing practitioner.

Prescriber Name:	◯MD ◯DO ◯NP ◯PA	NPI:
Office Contact:	Practice name/Collaborating Physician:	
Address:	City:	

State:	Zip:	Phone:	Fax:

Patient Information | PLEASE SEND COPY OF INSURANCE CARD

Patient's Name:	Last 4 Digits of SS#:	DOB: / /	Sex: ◯ M ◯ F	Weight:	Height:	Diabetic: ◯ Y ◯ N
Address:	City:	State:	Zip:	Allergies:		

Home Phone:	Work Or Cell:	HIPAA Contact:	Emergency #:	Interpreter Needed? ◯Y ◯N

Clinical Information | PLEASE SEND COPY OF MEDICAL AND PRESCRIPTION INSURANCE CARDS, PROGRESS NOTES AND LAB REPORTS, SUPPORTING DIAGNOSIS, CO-MORBIDITIES AND LAB VALUES

Diagnosis: ◯M32.9 Active Systemic Lupus Erythematosus ◯ M45.9 Ankylosing Spondylitis ◯ M08.0 Juvenile Idiopathic Arthritis ◯ L40.59 Psoriatic Arthritis

◯ L40.54 Psoriatic Juvenille Arthritis ◯ M06.9 Rheumatoid Arthritis ◯ Other:

Date of Diagnosis: / /	Date of Negative TB Test: / /	Any prior treatment? ◯ Yes ◯ No (provide information below)	
Prior Therapy	Reason for Discontinuation of Therapy	Approximate Start Date	Approximate End Date

Comorbidities:	Concomitant Medications:

Allergies: ◯ NKDA ◯ Other:

TREATMENT ARRANGEMENTS:	Ship Meds: ◯ Home ◯ Prescriber's Office	Start Date: / /	

Prescription Information

Medication	Quantity/Dose	Sig	Refills
◯ **ACTEMRA®** ◯ PFS	◯ 2 cartons (2x162mg/0.9ml) ◯ 4 cartons (4x162mg/0.9ml)	◯ Inject 162 mg SQ every other week (<100kg) ◯ Inject 162 mg SQ every week (>100kg)	
◯ **BENLYSTA®** ◯ PFS ◯ Pen	◯ 1 carton (4x200mg/ml autoinjector) ◯ 1 carton (4x200mg/ml PFS)	◯ **Maintenance Dose:** Administer 200mg SQ once every week	
◯ **CIMZIA®** ◯ PFS ◯ Vial	◯ **PFS Only:** Starter Kit (6x200mg/ml)	◯ **Starter Dose:** Inject 400 mg SQ at weeks 0, 2, and 4	**No Refills**
	◯ 1 carton (2x200 mg/ml)	◯ **Maintenance Dose:** Inject 400 mg SQ every 4 weeks ◯ **Maintenance Dose:** Inject 200 mg SQ every 2 weeks	
◯ **COSENTYX®** ◯ PFS ◯ Sensoready® Pen	◯ 4 cartons (8x150mg/ml) ◯ 4 cartons (4x150mg/ml)	◯ **Starter Dose:** Inject 300 mg SQ at weeks 0, 1, 2, 3 ◯ **Starter Dose:** Inject 150 mg SQ at weeks 0, 1, 2, 3	**No Refills**
	◯ 1 carton (2x150mg/ml) ◯ 1 carton (1x150mg/ml)	◯ **Maintenance Dose:** Inject 300 mg SQ every 4 weeks beginning on Day 29 ◯ **Maintenance Dose:** Inject 150 mg SQ every 4 weeks beginning on Day 29	
◯ **ENBREL®** ◯ Mini® ◯PFS ◯SureClick® ◯Vial	◯ 1 carton (4 x 50mg/ml) ◯ Other:	◯ Inject 50 mg SQ every week ◯ Other Regimen:	
◯ **HUMIRA®** ◯ PFS ◯ Pen	◯ 1 carton (2x40mg/0.8ml) ◯ 2 cartons (4x40mg/0.8ml) ◯ Citrate Free: 1 carton (2x40mg/0.4ml) ◯ Citrate Free: 2 cartons (4x40mg/0.4ml)	◯ Inject 40 mg SQ every 14 days ◯ Inject 40 mg SQ every 7 days	
◯ **HUMIRA®** (Pediatric)	◯ 1 carton (2x10mg/0.1mL PFS) ◯ 1 carton (2x20mg/0.2mL PFS) ◯ 1 carton (40mg/0.4mL PFS) ◯ 1 carton (40mg/0.4mL PEN)	◯ **Weight 10-14kg:** Inject 10mg SQ every other week ◯ **Weight 15-29kg:** Inject 20mg SQ every other week ◯ **Weight ≥30kg:** Inject 40mg SQ every other week	
◯ **HUMIRA®** (Uveitis) ◯ PFS ◯ Pen	**Pens Only:** ◯ Starter Kit (4x40mg/0.8ml) ◯ Citrate Free Starter Kit (1x80mg/0.8ml, 2x40mg/0.4ml)	◯ Inject 80mg SQ on Day 1, then 40mg on day 8, then 40mg every 2 weeks	**No Refills**
	◯ 1 carton (2x40mg/0.8 ml) ◯ Citrate Free 1 carton (2x40mg/0.4ml)	◯ Inject 40mg SQ every 14 days	

Injection Training

◯ Patient received pens and injection training ◯ Physician's office to provide injection training ◯ VascoRx to coordinate injection training or infusion

By signing this form and utilizing our services, you are authorizing VascoRx and its employees to serve as your prior authorization agent in dealing with medical and prescription insurance companies and copay assistance foundation.

Prescriber Signature: Date	Prescriber Signature: Date
Substitution Permitted	Dispense as Written

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