Rheumatology Enrollment Form (K-Z)

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

VASCO SPECIALTY-INFUSION
An AleraCare Company

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

Prescriber Information

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
◯ **KEVZARA**® ◯PFS ◯Pen	◯1 carton (2x200mg/1.14ml) ◯1 carton (2x150mg/1.14ml)	◯Inject 200mg SQ every 2 weeks ◯Inject 150mg SQ every 2 weeks	
◯ **OLUMIANT**®	◯2mg tablet (30 day supply)	◯Take 1 tablet by mouth once daily	
◯ **ORENCIA**® ◯Clickject® ◯PFS	◯1 carton (4x125mg/ml)	◯ **Maintenance Dose**: Inject 125 mg SQ once every week	
◯ **OTEZLA**®	◯Starter Pack 10/20/30mg tablets (55 tabs for 28 days)	◯ **Starter Dose:** Take as directed per package instructions	**No Refills**
	◯30 mg tablet (60 tablets)	◯ **Maintenance Dose:** Take 1 tablet (30mg) by mouth twice daily	
◯ **OTREXUP**™ ◯Auto-injector	◯1 carton (4x10mg/0.4ml) ◯1 carton (4x20mg/0.4ml) ◯1 carton (4x12.5mg/0.4ml) ◯1 carton (4x22.5mg/0.4ml) ◯1 carton (4x15mg/0.4ml) ◯1 carton (4x25mg/0.4ml) ◯1 carton (4x17.5mg/0.4ml)	◯Inject _____mg SQ every week	
◯ **RASUVO**® ◯Auto-injector	◯4x7.5mg/0.15ml ◯4x20mg/0.4ml ◯4x10mg/0.20ml ◯4x22.5mg/0.45ml ◯4x12.5mg/0.25ml ◯4x25mg/0.50ml ◯4x15mg/0.30ml ◯4x30mg/0.60ml ◯4x17.5mg/0.35ml	◯Inject _____mg SQ every week	
◯ **RINVOQ**™	◯15mg tablet (30 day supply)	◯Take 1 tablet by mouth once daily	
◯ **SIMPONI**® ◯SmartJect® ◯PFS	◯1 carton (1x50mg/0.5ml)	◯Inject 50 mg SQ once every month	
◯ **STELARA**® ◯PFS Patient eligible for self-injection? ◯Yes ◯No	◯1 carton (1x45mg/0.5ml) ◯1 carton (1x90mg/ml)	◯ **Starter Dose:** Inject 45 mg SQ on day 1 (<100kg) ◯ **Starter Dose:** Inject 90 mg SQ on day 1 (>100kg)	**No Refills**
		◯ **Maintenance Dose:** Inject 45 mg SQ on day 29 and every 12 weeks thereafter (<100kg) ◯ **Maintenance Dose:** Inject 90 mg SQ on day 29 and every 12 weeks thereafter (>100kg)	
◯ **XELJANZ**®	◯5 mg tablets (60 tablets)	◯Take 1 tablet (5 mg) by mouth twice a day	
◯ **XELJANZ® XR**	◯11 mg tablets (30 tablets)	◯Take 1 tablet (11mg) by mouth every day	

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 Substitution Permitted	Prescriber Signature: Date Dispense as Written