# Lumicera Health Services

# Rheumatoid Arthritis Enrollment Form

2601 West Beltline Hwy, Ste 302, Madison, WI 53713 / Phone: (855) 847-3553 / Fax: (855) 847-3558

Ship to: ○ Patient ○ Office ○ Other  Date:  Needs by Date:

## PATIENT INFORMATION

Patient Name
Address
Address 2
City, State, ZIP
Preferred Phone  Type
Alternate Phone  Type
Email
DOB (mm/dd/yyyy)  Gender ○ Male ○ Female

## PRESCRIBER INFORMATION

Prescriber Name  Specialty
State License #  UPIN
DEA  NPI
Group/Hospital
Address
City, State, ZIP
Phone  Fax
Office Contact  Phone

## INSURANCE INFORMATION *(Please fax FRONT and BACK copy of all Insurance cards (Prescription and Medical)*

## CLINICAL INFORMATION

**Diagnosis (***Please include diagnosis name and ICD-10 code)*

Primary Diagnosis: ○ Rheumatoid Arthritis ○ Juvenile Idiopathic Arthritis
○ Ankylosing Spondylitis Other Diagnosis:
ICD-10:
Date of Diagnosis:
Weight: lbs/kgs Height : in/cm
Is the patient pregnant, nursing, or planning pregnancy?: ○ Yes ○ No ○ N/A
Date of last TB test (PPD or QuantiFERON Gold):
Results: ○ Positive ○ Negative
Allergies:
Concomitant medications:

Therapy: ○ New ○ Continuing Therapy ○ Restart

Lab Data: Rheumatoid factor, ESR, CRP and/or other applicable information:

Has the patient been previously treated for this condition? ○ Yes ○ No
Prior failed medication (medication and duration of treatment/reason for d/c):

Who will administer injection? (if applicable):
Patient trained on injection? (if applicable): ○ Yes ○ No
Pharmacy injection training needed? (if applicable): ○ Yes ○ No
Additional comments:

## PRESCRIPTION INFORMATION

| Medication | Dose/Strength | Directions | Qty | Refills |
|---|---|---|---|---|
| ○ Actemra® (**tocilizumab**) | ○ 162mg/0.9ml prefilled syringe | ○ 162mg every other week (< 100 kg or 220 lbs)<br>○ 162mg every week (≥ 100 kg or 220 lbs) | | |
| ○ Cimzia® (**certolizumab pegol**) | ○ 200mg/ml prefilled syringe<br>○ 200mg/ml vial kit | ○ 400mg subcutaneously at week zero, two and four followed by 200mg every other week (starter pack)<br>○ 400mg every four weeks<br>○ 200mg every other week | | |
| ○ Enbrel® (**etanercept**) | ○ 25mg/0.5ml syringe<br>○ or multi-dose vial (circle one)<br>○ 50mg/ml syringe<br>○ or Sureclick Pen (circle one) | ○ 50mg subcutaneously once weekly<br>○ Other: | | |
| ○ Humira® (**adalimumab**) | ○ 40mg/0.8ml pen or syringe (circle one)<br>○ 40mg/10.8ml prefilled syringe | ○ 40mg subcutaneously every other week<br>○ 40mg subcutaneously once weekly<br>○ Other: | | |
| ○ Orencia® (**abatacept**) | ○ 125mg/ml prefilled syringe<br>○ 125mg/ml clickject pen | ○ 125mg subcutaneously once weekly | | |
| ○ Simponi® (**golimumab**) | ○ 50mg/0.5ml smartject pens<br>○ 50mg/10.5ml prefilled syringe | ○ 50mg subcutaneously once monthly | | |
| ○ Xeljanz® (**tofacitinib citrate**) | ○ 5mg tablet<br>○ 11mg xr tablet | ○ 5mg twice daily<br>○ 5mg once daily<br>○ 11mg xr once daily | | |

By signing below, I authorize Lumicera Health Services and its representatives to act as my agent for prior authorization and prescription processing for this patient.

Prescriber Signature: _____ Date _____

*PRODUCT SUBSTITUTION PERMITTED*  *DISPENSE AS WRITTEN*