

Rheumatoid Arthritis Enrollment Form

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)

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 Reauthorization Restart

Lab Data: Rheumatoid factor, ESR, CRP and/or other available 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
<input type="radio"/> Actemra® (tocilizumab)	<input type="radio"/> 162mg/0.9ml prefilled syringe	<input type="radio"/> 162mg every other week (< 100 kg or 220 lbs) <input type="radio"/> 162mg every week (> 100 kg or 220 lbs)		
<input type="radio"/> Cimzia® (certolizumab pegol)	<input type="radio"/> 200mg/ml prefilled syringe	<input type="radio"/> 400mg subcutaneously at week zero, two and four followed by 200mg every other week (starter pack) <input type="radio"/> 400mg every four weeks <input type="radio"/> 200mg every other week <input type="radio"/> Other:		
<input type="radio"/> Enbrel® (etanercept)	<input type="radio"/> 25mg/0.5ml syringe or multi-dose vial (circle one) <input type="radio"/> 50mg/ml syringe or Sureclick Pen (circle one)	<input type="radio"/> 50mg subcutaneously once weekly <input type="radio"/> 50mg twice weekly X 12 weeks, then once weekly (Derm) <input type="radio"/> Other:		
<input type="radio"/> Humira® (adalimumab)	<input type="radio"/> 20mg/0.4ml syringe <input type="radio"/> 40mg/0.8ml pen or syringe (circle one)	<input type="radio"/> 40mg subcutaneously every other week <input type="radio"/> 40mg subcutaneously once weekly <input type="radio"/> Other:		
<input type="radio"/> Kineret® (anakinra)	<input type="radio"/> 100mg/0.67ml	<input type="radio"/> 100mg subcutaneously daily <input type="radio"/> Other:		
<input type="radio"/> Orencia® (abatacept)	<input type="radio"/> 125mg/ml	<input type="radio"/> 125mg subcutaneously once weekly <input type="radio"/> Other:		
<input type="radio"/> Simponi® (golimumab)	<input type="radio"/> 50mg/0.5ml pen/ syringe	<input type="radio"/> 50mg subcutaneously once monthly <input type="radio"/> Other:		
<input type="radio"/> Xeljanz® (tofacitinib citrate)	<input type="radio"/> 5mg tablet	<input type="radio"/> 5mg twice daily <input type="radio"/> 5mg once daily <input type="radio"/> Other:		

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: _____

PRODUCT SUBSTITUTION PERMITTED

Date _____

DISPENSE AS WRITTEN