Elite Specialty Pharmacy
Your Choice Above The Rest

Rheumatology Enrollment Form

Fax Referrals To: (877) 577-6447

Nzone-Elite Specialty Pharmacy
10210 101st Ave
Ozone Park, NY 11416
Toll Free: (877) 577-1447

PATIENT INFORMATION

Patient Name: ________________________________ Date of Birth: ____ /____ / ______ ☐ Male ☐ Female (Childbearing) SSN: ____ -____ - ____
Address: ____ City: ________________________ State: ________ Zip: ________________
Phone: (____) - ____ - ________ Alternate Phone: (____) - ____ - ________ email: ______________________________________
Preferred method of contact: ☐ Phone ☐ Email ☐ Other: ______________________ Height: _______ in Weight: ________ lb

PRESCRIPTION BENEFITS PROVIDER

Provider: ___________________________________
Phone: (____) - ____ - ________
ID #: ____________________ Group #: ________
Rx BIN: __________ Rx PCN: __________

(Please fax copy of front and back of card)

PRESCRIBER INFORMATION

Prescriber Name: ____
Office Phone: _________________________ Fax: _________________________
Clinic/Hospital Affiliation: ____
Address: ________________________ City, State, Zip: ______________________
License #: _________________ NPI #: ____________________ Contact ________

CLINICAL INFORMATION

☐ M06.9 Rheumatoid arthritis, unspecified ☐ L40.54 Psoriatic juvenile arthropathy ☐ L40.59 Other Psoriatic Arthopahy
☐ M46.9 Ankylosing spondylitis ☐ M46.9 Ankylosing spondylitis unspecified ☐ Other: ____

TB/PPD Test Results: ☐ Positive ☐ Negative Date: ___________ Current Medications: ____
Allergies: ☐ NKDA ☐ Other: __________________________ ____

Prior Therapy	Reason for Discontinuation of Therapy	Approximate Start Date	Approximate End Date
____________________	____________________	__________	__________
____________________	____________________	__________	__________

Medication	Dosage & Strength	Direction	QTY	Refills
Actemra®	☐ Inject one 162 mg syringe SC every week	☐ Inject one 162 mg syringe SC every other week		
Cimzia®	☐ Cimzia Starter Kit ☐ Pre-filled Syringe ☐ Lyophilized Powder	☐ Induction dose: 400mg on day 1, week 2, and week 4 ☐ Maintenance dose: 200 mg SC weeks every 2 weeks		
Cosentyx®	☐ 150 mg Sensoready Pen ☐ 150 mg Pre-filled syringe	☐ **Initial**: Inject 150 mg subcutaneously at weeks 0, 1, 2, 3, and 4, then maintenance dose ☐ **Maintenance**: Inject 150 mg subcutaneously every 4 weeks ☐ **Initial**: Inject 300 mg (two 150 mg injections) SC at weeks 0, 1, 2, 3, and 4, then maintenance dose ☐ **Maintenance**: Inject 300 mg subcutaneously every 4 weeks		
Enbrel®	☐ 50 mg/mL Autoinjector ☐ 50 mg/mL Pre-filled syringe ☐ 25 mg vial	☐ Inject 50 mg SC ONCE a week ☐ Inject 25 mg SC TW ☐ Other: ______________		
Humira®	☐ 40 mg/0.8mL Pen ☐ 40 mg/0.8mL pre-filled syringe	☐ Inject 40 mg SC once every OTHER week ☐ Inject 40 mg SC EVERY week		
Kevzara®	☐ 150 mg/1.14mL Pre-filled syringe ☐ 200 mg/1.14mL Pre-filled syringe	☐ Inject 150 mg SC once every OTHER week ☐ Inject 200 mg SC once every OTHER week		
Kineret®	☐ Inject one 100 mg/0.67 mL pre-filled syringe SC daily			
Orencia®	☐ 125 mg/mL pre-filled syringe ☐ Inject 125 mg/mL ClickJect	☐ Inject 125 mg SC once weekly		
Otezla®	☐ Starter (Titration) Pak – take as directed X 28 Days ☐ Maintenance Dose – 30 mg twice daily by mouth			
Remicade®	☐ Induction dose: IV in 250 mL of 0.9% NaCl at weeks 0, 2, and 6 weeks Maintenance	☐ Maintenance dose: IV in 250 mL of 0.9% NaCl every 8 weeks (ICD-9 714.0 & 696.0) ☐ Maintenance dose: IV in 250 mL of 0.9% NaCl every 6 weeks (ICD-9 720.0)		
Stelara®	☐ 45mg/0.5mL Prefilled Syringe (≥ 220 lb) ☐ 90mg/0.5mL Prefilled Syringe (< 220 lb)	☐ Maintenance(≥ 220 lb): Inject 45mg SC every week at week 0, 4, then every 12 weeks ☐ Maintenance(< 220 lb): Inject 90mg SC every week at week 0, 4, then every 12 weeks		
Simponi®	☐ 50 mg/0.5 mL Autoinjector ☐ 50 mg/0.5 mL pre-filled syringe	☐ Inject SC once monthly Other: ____________________		
Xeljanz®	☐ 5 mg ☐ Take 5 mg by mouth twice daily	☐ 11mg XR ☐ Take 11g by mouth once daily		

By signing below, I authorize Nzone Pharmacy, LLC and its representatives to act as an agent to initiate and execute the insurance prior authorization process. I also certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge.

Prescriber's signature: ______________________________ MD DO PA CRNP **Date:** ____ /____ / ____

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary on the prescription.

Ship to: Patient Physician/Clinic Date Shipment Needed By: ____ /____ / ____

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