Bell Pharmacy

Rheumatology Enrollment Form A-N

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PATIENT INFORMATION

Name:	Date of Birth:		O Male O Female
Address:	City:	State:	Zip:
Phone:	Alt Phone:		Email:
SS #:	Primary Language:		Emergency Contact:

PRESCRIBER INFORMATION

Prescribing Practitioner:				NPI#:
Supervising Physician:				NPI#:
Address:	City:	State:	Zip:	Tax ID:
Phone:	Fax:			Office Contact:

PRESCRIPTION INFORMATION

Needs by Date: Ship to: O Patients home O Prescriber 1st order only O Prescriber all orders O Other

Drug	Dose	Direction & Quantities	Refills
O Actemra®	O Vials O Pre-filled Syringe	O IV: Infuse _____ mg OR _____ mg/kg via IV every 4 weeks (Quantity: _____) O SQ: Inject 162 mg SQ every other week (Quantity: 2) O SQ: Inject 162 mg SQ every week (Quantity: 4)	
O Cimzia®	O Pre-filled Syringe O Vials	O INITIAL: Inject 400 mg SQ at Day 0, Day 14, and Day 28 (Quantity: 6) O MAINTENANCE: Inject 400 mg SQ every 4 weeks (Quantity: 2) O MAINTENANCE: Inject 200 mg SQ every 2 weeks (Quantity: 2)	
O Cosentyx ™	O Sensoready Pen O Pre-filled Syringe	O INITIAL: Inject 150 mg SQ on week 0, 1, 2, 3, and 4 (Quantity: 5) O MAINTENANCE: Inject 150 mg SQ every 4 weeks (Quantity: 1) O INITIAL: Inject 300 mg SQ on week 0, 1, 2, 3, and 4 (Quantity: 10) O MAINTENANCE: Inject 300 mg SQ every 4 weeks (Quantity: 2)	
O Enbrel®	O SureClick® Pen O Mini™ with AutoTouch™ O Pre-filled Syringe O 25 mg O 50 mg O Vials 25mg	O Inject 50 mg SQ every week (Quantity: 4) O Inject _____ mg (0.8 mg/kg x _____ kg) SQ every week	
O Humira® O Humira® CF	O Pen O Pre-filled Syringe	O UVEITIS INITIAL: Inject 80mg SQ on Day 1, 40mg on Day 8, then 40mg every other week (1 Kit) O MAINTENANCE: Inject 40 mg SQ every other week (Quantity: 2) O MAINTENANCE: Inject 40 mg SQ weekly (Quantity: 4)	
O Kevzara®	O Pre-filled Syringe O 150 mg O 200 mg	O Inject 150 mg SQ every 2 weeks (Qty: 2) O Inject 200 mg SQ every 2 weeks (Qty: 2)	

MEDICAL INFORMATION

** PLEASE FAX COPY OF PRESCRIPTION MEDICATION/MEDICAL CARD, FRONT AND BACK, AS WELL AS ANY CLINICAL NOTES REGARDING THERAPY **

PREVIOUS THERAPIES:	Tried & Failed (Duration):	Not Tolerated:	Contraindication:
O Methotrexate	O (_____)	O	_____
O Plaquenil	O (_____)	O	_____
O Sulfasalazine	O (_____)	O	_____
O Meloxicam	O (_____)	O	_____
O Naproxen / Aleve	O (_____)	O	_____
O Tramadol	O (_____)	O	_____
O Enbrel	O (_____)	O	_____
O Humira	O (_____)	O	_____
O Cimzia	O (_____)	O	_____
O _____	O (_____)	O	_____

O H20.9 Unspecified Iridocyclitis
O M06.9 Rheumatoid Arthritis, Unspecified
O M31.6 Other Giant Cell Arteritis
O M45.9 Ankylosing Spondylitis, Unspecified
O M31.5 Giant Cell Arteritis with Polymyalgia Rheumatica
O H20.0 Iridocyclitis (Uveitis), Unspecified Acute and Subacute
O M05.9 Rheumatoid Arthritis with Rheumatoid Factor, Unspecified
O M06.00 Rheumatoid Arthritis without Rheumatoid Factor, Unspecified
O M08.00 Unspecified Juvenile Rheumatoid Arthritis of Unspecified Site
O Other: _____

Date of Diagnosis: ____/____/____ Allergies: _____

Active TB is ruled out: O Yes O No Date: ____/____/_____ Hep B ruled out/treated: O Yes O No Date: ____/____/_____

Patient Height: _____ in/cm Weight: _____ kg/lbs

Additional Clinical Information:

INJECTION TRAINING

O Patient has received pen and injection training O Physician's office to provide injection training O Parkway Pharmacy to coordinate injection training

PRESCRIBING PRACTITIONER SIGNATURE

To Prescribing Practitioner: By signing this form and utilizing our services, you are also authorizing Parkway Pharmacy to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies, and co-pay assistance foundations.

_____

Prescribing Practitioner: Date

CONFIDENTIALITY NOTICE

Faxed Prescriptions will only be accepted from a prescribing practitioner.