Bell Pharmacy

Rheumatology Enrollment Form O-Z

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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 Olumiant	2mg Tablets	O Take 2 mg once daily (Qty: 30)	
O Orencia®	O Vials O Pre-filled Syringe O ClickJect™	INTRAVENOUS (IV): O INITIAL: Infuse _____ mg via IV on week 0, 2, and 4 (Qty: _____) O MAINTENANCE: Infuse _____ mg via IV every 4 weeks (Qty: _____) SUBCUTANEOUS (SQ): O Inject 125mg SQ once weekly (Qty: 4)	
O Otezla®	O 28 Day Starter Pack O Maintenance	O Take as directed per package instructions. (Qty: 55) O Take 30 mg PO twice daily (Qty: 60) O Take 30 mg PO once daily (Qty: 30). Renal Dosing. Continuation of Therapy: O Yes O No	
O Inflectra O Remicade O Renflexis	O 100 mg Vial O _____ mg/kg	O INITIAL: IV in 250ml of 0.9% NaCL at weeks 0, 2, and 6 weeks O MAINTENANCE: IV in 250ml of 0.9% NaCL every 8 weeks O MAINTENANCE: IV in 250ml of 0.9% NaCL every 6 weeks O Other: _____	
O Rinvoq	15mg Tablet	O Take 15 mg once daily (Qty: 30)	
O Rituxan	O 500mg/ 50 mL Vials	O Infuse 1000mg via IV on week 0 and week 2. Repeat every _____ months thereafter (Qty: 2 doses)	
O Simponi®	O SmartJect® (Pen) O Pre-filled Syringe	O Inject 50 mg SQ once a month (Qty: 1)	
O Simponi® Aria™	O 50mg Vials	O INITIAL: Infuse 2 mg/kg over 30 min at weeks 0 and 4 (Qty: 2 doses) Qty _____ vials O MAINTENANCE: Infuse 2 mg/kg over 30 min every 8 weeks thereafter (Qty: 1 dose) Qty _____ vials	
O Xeljanz®	5 mg Tablets	O Take 5 mg PO twice daily (Qty: 60)	
O Xeljanz® XR	11 mg Tablets	O Take 11 mg PO once daily (Qty: 30)	

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