Rheumatology Enrollment Form (A-G)

PYRAMIDS SPECIALTY PHARMACY

www.pyramidspharmacy.com

All our referral forms are available on our website.

10970 Shadow Creek Pkwy, Suite 110.1 I Pearland, TX 77584 I Phone: 1.888.375.1920 I Fax: 1.888.383.2140

1: Patient Information

Patient Name: _____ Birthdate: _____ Sex: ___Male ___Female Height: _____ Weight: _____ ❑lbs. ❑kg.

Soc. Sec. #: _____ Preferred Phone: _____ Known Allergies: _____

Address: _____ City: _____ State: _____ Zip: _____

Insurance Information: Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)

Plan Name: _____ Plan Phone: _____

ID #: _____ Group #: _____ RxBIN: _____ RxPCN: _____

2: Prescriber Information

Prescriber Name: _____ DEA#: _____ NPI#: _____ Tax ID#: _____

Address: _____ Phone: (_____) _____ - _____ Fax: (_____) _____ - _____

City: _____ State: _____ Zip: _____ Key Contact: _____ Phone: (_____) _____ - _____

3: Diagnosis/Clinical Information | *Please FAX recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization*

Diagnosis (ICD-10):

❑ M06.9 Rheumatoid Arthritis, Unspecified
❑ M45.9 Ankylosing Spondylitis
❑ M08.00 Juvenile Rheumatoid Arthritis
❑ L40.50 Arthropathic Psoriasis
❑ Other: _____

TB Test Completed: ❑ Yes ❑ No
Date of Negative Test: _____

If history of latent TB, has patient received treatment? ❑ Yes ❑ No

Hep B Screening:
❑ Positive ❑ Negative ❑ N/A
Date of Hep B Test: _____

Does the patient have an active infection?
❑ Yes ❑ No

Concomitant Medications: _____

Please list previously tried and failed therapies & reason for discontinuing:

❑ Azathioprine: _____
❑ Corticosteroids: _____
❑ Leflunomide: _____
❑ Methotrexate: _____
❑ NSAIDs: _____
❑ Hydroxychloroquine: _____
❑ Sulfasalazine: _____
❑ Other: _____

4: Prescription Information

Medication	Strength	Directions	Quantity	Refills
❑ Actemra®	❑ 80 mg/4mL ❑ 200 mg/10mL ❑ 400 mg/20mL *Patient Dosing Wt:* _____*kg*	❑ **Initial Dose**: Infuse _____ mg (4mg/kg) IV every 4 weeks. ❑ **Maintenance Dose**: Infuse _____ mg (8mg/kg) IV every 4 weeks. ❑ Other: _____		
	❑ 162 mg/0.9 mL Prefilled Syringe	❑ **For Patients Weighing < 100 kg**: Inject 162 mg subQ every other week, followed by an increase to every week based on clinical response. ❑ **For Patients Weighing ≥ 100 kg**: Inject 162 mg subQ every week.		
❑ Cimzia®	❑ Cimzia Starter Kit	❑ **Initial Dose:** Inject 400 mg (two 200 mg injections) subQ at Weeks 0, 2, and 4, then maintenance dose.	1 Kit	0
	❑ 200 mg Vial ❑ 200 mg Prefilled Syringe	❑ **Maintenance Dose**: ❑ Inject 200 mg subQ every *other* week. ❑ Inject 400 mg subQ every 4 weeks.		
❑ Cosentyx®	❑ 150 mg Sensoready Pen ❑ 150 mg Prefilled Syringe	*Psoriatic Arthritis and AS* ❑ **Initial Dose**: Inject 150 mg subQ at Weeks 0, 1, 2, 3, and 4, then maintenance dose. ❑ **Maintenance Dose**: Inject 150 mg subQ every 4 weeks. *Psoriatic Arthritis with coexistent Plaque Psoriasis* ❑ **Initial Dose**: Inject 300 mg (two 150 mg injections) subQ at Weeks 0, 1, 2, 3, and 4, then maintenance dose. ❑ **Maintenance Dose**: Inject 300 mg subQ every 4 weeks. *Cosentyx Service Request Form available at www.pyramidspharmacy.com*		
❑ Enbrel®	❑ 25 mg/0.5 mL Prefilled Syringe ❑ 25 mg Vial ❑ 50 mg/mL Sureclick™ Autoinjector ❑ 50 mg/mL Prefilled Syringe ❑ 50 mg/mL Enbrel Mini™ Prefilled Cartridge for use with the Auto-Touch™ reusable autoinjector only	❑ Inject 50 mg subQ *once* a week. ❑ Inject 25 mg subQ *twice* a week. ❑ Other: _____		

Deliver to: ❑Patient ❑Office ❑Other: _____ Date: _____ Needs by Date: _____

*Prescriber Authorization: I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

❑Product Substitution Permitted ❑Dispense as Written

STAMP SIGNATURE NOT ALLOWED Prescriber's Signature: _____ Date: _____