Rheumatology Enrollment Form (R-Z)

www.pyramidspharmacy.com

All our referral forms are available on our website.

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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
❑ Remicade®	❑ 100 mg Vial *Patient Dosing Wt:* ________*kg*	❑ **Initial Dose**: Infuse ________ mg/kg IV at Weeks 0, 2, and 6, then maintenance dose. ❑ **Maintenance Dose**: Infuse ________ mg/kg IV every 6 weeks. ❑ **Maintenance Dose**: Infuse ________ mg/kg IV every 8 weeks. ❑ Other: ______________		
❑ Renflexis®	❑ 100 mg Vial *Patient Dosing Wt:* ________*kg*	❑ **Initial Dose**: Infuse ________ mg/kg IV at Weeks 0, 2, and 6, then maintenance dose. ❑ **Maintenance Dose**: Infuse ________ mg/kg IV every 6 weeks. ❑ **Maintenance Dose**: Infuse ________ mg/kg IV every 8 weeks. ❑ Other: ______________		
❑ Simponi®	❑ 50 mg Autoinjector ❑ 50 mg Prefilled Syringe	❑ Inject 50 mg subQ once a month.		
❑ Simponi Aria®	❑ 50 mg/4 mL Single-Use Vial *Patient Dosing Wt:* ________*kg*	❑ **Initial Dose**: Infuse _____ mg (2mg/kg) IV over 30 minutes at Weeks 0, 4, then maintenance dose. ❑ **Maintenance Dose**: Infuse _____ mg (2mg/kg) IV over 30 minutes every 8 weeks.		
❑ Stelara®	❑ 45 mg/0.5 mL Prefilled Syringe **(PsA)** ❑ 90 mg/mL Prefilled Syringe **(PsA with coexistent Psoriasis patients > 100 kg)**	❑ **Initial Dose**: Inject one syringe subQ at Weeks 0 and 4, then maintenance dose. ❑ **Maintenance Dose**: Inject one syringe subQ every 12 weeks.		
❑ Taltz®	❑ 80 mg Autoinjector ❑ 80 mg Prefilled Syringe	❑ **Initial Dose**: Inject 160 mg (two 80 mg injections) subQ on Day 1, then maintenance dose starting Day 29. ❑ **Maintenance Dose**: Inject 80 mg subQ every 4 weeks.		
❑ Xeljanz®	❑ 5 mg tablet	❑ Take one tablet by mouth twice daily.		
❑ Xeljanz® XR	❑ 11 mg tablet	❑ Take one tablet by mouth once daily.		

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: ______________

CONFIDENTIALITY STATEMENT: This communication is intended for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential, and exempt from disclosure under applicable law. If the reader of this communication is not the intended recipient or the employee or agent responsible for delivery of the communication, you are hereby notified that any dissemination, distribution, or copying of the communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone.