



Rheumatology Enrollment Form (H-Q)

www.pyramidsparmacy.com

All our referral forms are available on our website.

10970 Shadow Creek Pkwy, Suite 110.1 | Pearland, TX 77584 | Phone: 1.888.375.1920 | 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
<input type="checkbox"/> Humira®	Uveitis Starter Kit <input type="checkbox"/> 40 mg/0.8 mL Pen <input type="checkbox"/> 40 mg/0.4 mL Pen (citrate-free) <input type="checkbox"/> 80 mg/0.8 mL Pen (citrate-free) <input type="checkbox"/> 40 mg/0.8 mL PFS <input type="checkbox"/> 40 mg/0.4 mL PFS (citrate-free)	<u>Uveitis Initial Dose</u> <input type="checkbox"/> Inject 80 mg subQ on Day 1, then 40mg on Day 8, then 40 mg on Day 22, followed by maintenance dose. <u>RA, PsA, AS, and Uveitis Maintenance Dose</u> <input type="checkbox"/> Inject 40 mg subQ every <u>other</u> week. <input type="checkbox"/> Other: _____	1 Kit	0
<input type="checkbox"/> Inflectra®	<input type="checkbox"/> 100 mg Vial <i>Patient Dosing Wt:</i> _____ kg	<input type="checkbox"/> Initial Dose: Infuse _____ mg/kg IV at Weeks 0, 2, and 6, then maintenance dose. <input type="checkbox"/> Maintenance Dose: Infuse _____ mg/kg IV every 6 weeks. <input type="checkbox"/> Maintenance Dose: Infuse _____ mg/kg IV every 8 weeks. <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Kevzara®	<input type="checkbox"/> 150 mg/1.14 mL Pen <input type="checkbox"/> 200 mg/1.14 mL Pen <input type="checkbox"/> 150 mg/1.14 mL PFS <input type="checkbox"/> 200 mg/1.14 mL PFS	<input type="checkbox"/> Inject 150 mg subQ every 2 weeks (if lab abnormalities). <input type="checkbox"/> Inject 200 mg subQ every 2 weeks.		
<input type="checkbox"/> Olumiant®	<input type="checkbox"/> 2 mg tablet	<input type="checkbox"/> Take one tablet by mouth once daily with or without food.		
<input type="checkbox"/> Orencia®	<input type="checkbox"/> 250 mg Vial <i>Patient Dosing Wt:</i> _____ kg <input type="checkbox"/> 125 mg/mL Prefilled Syringe <input type="checkbox"/> 125 mg/mL Autoinjector	<input type="checkbox"/> Initial Dose: Infuse _____ mg IV at Weeks 0, 2, and 4, followed by maintenance dose. <input type="checkbox"/> Maintenance Dose: Infuse _____ mg IV every 4 weeks. <input type="checkbox"/> Inject 125 mg subQ every week.		
<input type="checkbox"/> Otezla®	<input type="checkbox"/> Titration Starter Pack <input type="checkbox"/> 30 mg tablet	<input type="checkbox"/> Initial Dose: Take as directed on starter pack. <input type="checkbox"/> Maintenance Dose: Take one tablet (30 mg) by mouth twice daily. <input type="checkbox"/> Other: _____ <i>Otezla START Form available at www.pyramidsparmacy.com</i>	1 Starter Pack	0

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.