



Rheumatology Enrollment Form O-Z

Date: _____

Patient Data

Patient Name: _____ Birthdate: _____ Sex: Male Female Height: _____ Weight: _____ lbs kg
 SSN #: XXX-XX-_____
 Address: _____ City: _____ State: _____ Zip: _____
 Home Phone: _____ Cell Phone: _____ Primary Language: _____
 Alternate Caregiver Name: _____ Phone of Caregiver: _____

Ins. Data

Primary Insurance: _____ Secondary Insurance: _____
 Policy: _____ Group#: _____ Policy: _____ Group#: _____

Clinical Information

To expedite prior authorization, please attach PPD results, lab results, clinical office notes, and past treatment history.

Diagnosis : M06.9 Rheumatoid Arthritis M33.00 Juvenile Rheumatoid Arthritis L40.52 Psoriatic Arthritis M45.9 Ankylosing Spondylitis
 M32.9 Systemic Lupus M32.14 Lupus Nephritis Other: _____
 Does patient have a latex allergy? Yes No Has patient been tested for Hepatitis B? Yes No If positive, has treatment been initiated? Yes No
 Has patient received PPD (tuberculosis) skin test: Yes No Date: _____ Results: Positive Negative
 Has patient previously been treated for this condition: Yes No Joints Affected: _____
 If yes, medication/therapy failed (length of therapy): _____ Injection training needed: Yes No

Prescription

Medication	Strength	Directions	Quantity	Refills
<input type="checkbox"/> Olumiant®	2mg tablet	Take 1 tablet orally once daily	#30	
<input type="checkbox"/> Orencia®	<input type="checkbox"/> 125mg/ml PFS <input type="checkbox"/> 125mg/ml ClickJect™ autoinjector	Inject 125mg SQ every 7 days	#4	
<input type="checkbox"/> Otezla®	<input type="checkbox"/> Titration Starter Pack	Induction: Use as directed per titration pack instructions	#1 pack	0 refills
	<input type="checkbox"/> 30mg tablet	Maintenance: Take 1 tablet orally twice daily	#60	
<input type="checkbox"/> Otrexup®	<input type="checkbox"/> 10mg/0.4ml autoinjector	Inject 1 pen SQ once weekly	#4	
	<input type="checkbox"/> 12.5mg/0.4ml autoinjector			
	<input type="checkbox"/> 15mg/0.4ml autoinjector			
	<input type="checkbox"/> 17.5mg/0.4ml autoinjector			
	<input type="checkbox"/> 20mg/0.4ml autoinjector			
	<input type="checkbox"/> 22.5mg/0.4ml autoinjector			
<input type="checkbox"/> 25mg/0.4ml autoinjector				
<input type="checkbox"/> Rinvoq™	15mg tablet	Take 1 tablet orally once daily	#30	
<input type="checkbox"/> Simponi®	<input type="checkbox"/> 50mg/0.5ml PFS	Inject 50mg SQ once every 28 days	#1	
	<input type="checkbox"/> 50mg/0.5ml SmartJect autoinjector			
<input type="checkbox"/> Stelara®	<input type="checkbox"/> 45mg/0.5ml PFS <input type="checkbox"/> 90mg/1ml PFS	<i>Patient weight 100kg or less</i> <input type="checkbox"/> Induction: Inject 45mg SQ at weeks 0 and 4	#2	0 refills
		<input type="checkbox"/> Maintenance: Inject 45mg SQ every 12 weeks Patient weight _____kg	#1	
		<i>Patient weight greater than 100kg</i> <input type="checkbox"/> Induction: Inject 90mg SQ at weeks 0 and 4	#2	0 refills
		<input type="checkbox"/> Maintenance: Inject 90mg SQ every 12 weeks Patient weight _____kg	#1	
<input type="checkbox"/> Taltz®	<input type="checkbox"/> 80mg/ml PFS <input type="checkbox"/> 80mg/ml autoinjector	<input type="checkbox"/> Induction: Inject 160mg (2 injections) SQ at week 0	#2	0 refills
		<input type="checkbox"/> Maintenance: Inject 80mg SQ every 4 weeks	#1	
<input type="checkbox"/> Xeljanz®	5mg tablet	Take 1 tablet orally twice daily	#60	
<input type="checkbox"/> Xeljanz XR®	11mg tablet	Take 1 tablet orally once daily	#30	

Is patient new to this therapy: YES NO | Ship to: Patient Office Other | Need by Date: _____

Prescriber Data

Prescriber Name: _____ DEA#: _____ NPI: _____
 Practice Name: _____ Contact: _____
 Address: _____ Phone: _____ Fax: _____
 City: _____ State: _____ Zip: _____ Key Contact#: _____

My signature below authorizes Value Specialty Pharmacy staff to act as my authorized agent to complete the insurance prior authorization process for my patient listed above. My authorization shall include any required signatures by Value Specialty Pharmacists on my behalf to facilitate this process and acknowledge their authorized access to necessary healthcare data to complete said process.

Physician Signature: _____ Date: _____

This prescription will be filled generically unless prescriber writes "DAW" in the box to the right.