



Rheumatology Enrollment Form A-K

Patient Data

Patient Name: _____ Birthdate: _____ Sex: Male Female Height: _____ Weight: _____ lbs kg
 SSN #: XXX-XX-____ Known Allergies: _____
 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"/> Actemra®	<input type="checkbox"/> 162mg/0.9ml PFS	<i>Patients less than 100kg</i> <input type="checkbox"/> Inject 162mg SQ every 14 days	#2	
	<input type="checkbox"/> 162mg/0.9ml ActPen	<i>Patients 100kg or above</i> <input type="checkbox"/> Inject 162mg SQ every 7 days	#4	
<input type="checkbox"/> Benlysta	<input type="checkbox"/> 200mg/ml PFS <input type="checkbox"/> 200mg/ml autoinjector	Inject 200mg SQ once weekly	#4	
<input type="checkbox"/> Cimzia®	<input type="checkbox"/> 200mg/ml PFS <input type="checkbox"/> 200mg/ml vial	<input type="checkbox"/> Induction: Inject 400mg SQ at weeks 0, 2, and 4	#6	0 refills
		<input type="checkbox"/> Maintenance: Inject 400mg SQ every 4 weeks <input type="checkbox"/> Maintenance: Inject 200mg SQ every 14 days	#2	
<input type="checkbox"/> Cosentyx®	<input type="checkbox"/> 150mg/ml PFS <input type="checkbox"/> 150mg/ml pen	<input type="checkbox"/> Induction: Inject 150mg SQ at weeks 0, 1, 2, 3, and 4	#5	0 refills
		<input type="checkbox"/> Maintenance: Inject 150mg SQ every 4 weeks <input type="checkbox"/> Maintenance: Inject 300mg (two injections) SQ every 4 weeks		
<input type="checkbox"/> Enbrel®	<input type="checkbox"/> 50mg/ml PFS <input type="checkbox"/> 50mg/ml SureClick™ Autoinjector <input type="checkbox"/> 50mg/ml mini cartridge <i>AutoTouch device available only through RxCrossroads</i> <input type="checkbox"/> 25mg/0.5ml PFS <input type="checkbox"/> 25mg/0.5ml vial	<input type="checkbox"/> Inject 25mg SQ every 7 days	#4	
		<input type="checkbox"/> Inject 50mg SQ every 7 days		
<input type="checkbox"/> Humira® <i>Citrate Free</i>	<input type="checkbox"/> 40mg/0.4ml PFS <input type="checkbox"/> 40mg/0.4ml pen <input type="checkbox"/> 80mg/0.8ml PFS <input type="checkbox"/> 80mg/0.8ml pen	<input type="checkbox"/> Inject 40mg SQ every 14 days	#2	
		<input type="checkbox"/> Inject 80mg SQ every 14 days		
<input type="checkbox"/> Kevzara®	<input type="checkbox"/> 150mg/1.14ml PFS <input type="checkbox"/> 150mg/1.14ml pen	Inject 150mg SQ every 14 days	#2	
		<input type="checkbox"/> 200mg/1.14ml PFS <input type="checkbox"/> 200mg/1.14ml pen	Inject 200mg SQ every 14 days	#2

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.

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