



# Rheumatology Enrollment Form O-Z

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"/> 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.