encore pharmacy

RHEUMATOLOGY ENROLLMENT FORM
Fax to: 512-490-6515

DATE: _____
DATE NEEDED: _____

SHIP TO: ☐ PATIENT ☐ OFFICE

PHARMACY LOCATION
Phone: 512-381-1708
Toll Free: 855-241-6658
11209 Metric Blvd., Suite B4
Austin, TX 78758

PATIENT INFO

NAME _____ E-MAIL _____ DOB _____ ☐MALE ☐FEMALE

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME TELEPHONE _____ MOBILE PHONE _____ SS# _____

PLEASE FAX COPY OF INSURANCE CARD (FRONT & BACK)

CLINICAL INFORMATION

DIAGNOSIS CODES
☐ M06.9 Rheumatoid Arthritis ☐ M08.00 Juvenile Idiopathic Arthritis ☐ M45.9 Ankylosing Spondylitis ☐ L40.52 Psoriatic Arthritis
☐ Date of Diagnosis: _____ Other: _____

TREATMENT HISTORY
☐ New to this medicine ☐ Continued Treatment - If continuing treatment, has patient's condition improved or stabilized? ☐ Yes ☐ No
Patient Weight: _____kg / lb TB/PPD Test Results? ☐ Negative ☐ Positive ☐ N/A Allergies? ☐ Latex ☐ Other: _____
Hepatitis B ruled out or being treated? ☐ Yes ☐ No ☐ N/A Concomitant Medications? ☐ Methotrexate ☐ Other: _____

PRIOR FAILED MEDICATION(S)
Medication _____ Medication _____
Length of Treatment _____ to _____ Length of Treatment _____ to _____
Reason for Discontinuing _____ Reason for Discontinuing _____

PRESCRIPTION INFORMATION

☐ ACTEMRA®	DIRECTIONS	QUANTITY
☐ 162mg/0.9ml PFS	☐ *(wt < 100kg):* Inject 162mg SC every *other* week ☐ *(wt > 100kg):* Inject 162mg SC every week ☐ _____mg/kg SC every *other* week ☐ Other _____	☐ 2 PFS/Pen ☐ 4 PFS/Pen Refills_____

☐ CIMZIA®	DIRECTIONS	QUANTITY
Starter: ☐ Starter Kit 200mg PFS ☐ 200mg/ml Vial & Supplies	Starter Directions: ☐ Inject 400mg SC at weeks 0, 2, and 4 ☐ Other: _____	☐ 1 PFS Kit (6x200 mg PFS) ☐ 2 PFS ☐ 4 Vials
Maintenance ☐ 200mg/ml PFS ☐ 200mg/ml Vial & Supplies	Maintenance Directions: ☐ Inject 200mg SC every *other* week ☐ Inject 400mg SC every 4 weeks ☐ Other: _____	☐ 6 Vials ☐ ____Vials Refills_____

☐ COSENTYX®	DIRECTIONS	QUANTITY
☐ 150mg/ml PFS ☐ 150mg/ml Pen	Starter: ☐ Ankylosing Spondylitis or Psoriatic Arthritis: Inject 150mg (1 pens / PFS) SC weekly at weeks, 0,1,2,3 and 4, then maintenance dosing.	☐ 5 Pen / PFS ☐ 10 Pens / PFS
	Starter: ☐ Psoriatic Arthritis with Coexistent Plaque Psoriasis : Inject 300mg (2 pens/PFS) SC weekly at weeks 0,1,2,3, and 4, then maintenance.	Refills_____
	Maintenance: ☐ Ankylosing Spondylitis or Psoriatic Arthritis: Inject 150mg SC every 4 weeks. ☐ Other: _____	☐ 1 Pens / PFS ☐ 2 Pens / PFS
	Maintenance: ☐ Psoriatic Arthritis with Coexistent Plaque Psoriasis : Inject 300mg SC every 4 weeks. ☐ Other: _____	Refills_____

☐ ENBREL®	DIRECTIONS	QUANTITY
☐ 50mg/ml SureClick Pen® ☐ 50mg/ml PFS ☐ 25mg/0.5ml PFS ☐ 25mg/0.5ml Vial ☐ 50mg/ml Mini cartridge	☐ Inject 50mg SC once a week ☐ Inject 50mg SC twice a week ☐ Inject 25mg SC twice a week ☐ __0.8mg/kg SC every week ☐ Other: _____	☐ 4 ☐ 8 Refills_____

☐ HUMIRA®	DIRECTIONS	QUANTITY
☐ 40mg/0.8ml pen ☐ 40mg/0.4ml pen (citrate-free) ☐ 40mg/0.8ml PFS ☐ 40mg/0.4ml PFS (citrate-free)	☐ Inject 40mg SC every *other* week ☐ Inject 40mg SC once a week ☐ Other _____	☐ 2 ☐ 4 Refills_____

☐ HUMIRA® FOR UVEITIS	DIRECTIONS	QUANTITY
Uveitis Starter ☐ UV Starter Kit ☐ UV Starter Kit (citrate-free)	Uveitis Induction Dose: ☐ Inject 80mg SC on Day 1, then 40mg SC on Day 8, then maintenance dosing.	☐ 1 Starter Kit
Uveitis Maintenance Dose: ☐ 40mg/0.8ml pen ☐ 40mg/0.4ml pen (citrate-free) ☐ 40mg/0.8ml PFS ☐ 40mg/0.4ml PFS (citrate-free)	Uveitis Maintenance Directions: ☐ Inject 40mg SC every other week ☐ Other: _____	☐ 2 Pens/PFS ☐ _____ Refills_____

☐ KEVZARA®	DIRECTIONS	QUANTITY
☐ 200mg / 1.14ml PFS ☐ 150mg / 1.14ml PFS	☐ Inject 1 PFS SC every other week ☐ Other _____	☐ 2 ☐ _____

☐ ORENCIA®	DIRECTIONS	QUANTITY
☐ 250mg/15ml Vial ☐ 125mg/ml PFS ☐ 125mg/ml ClickJect™ Pen	Starter: ☐ Initial: Infuse _____mg IV, then inject 125mg SC within 24 hrs Maintenance: ☐ Inject 125mg SC once a week ☐ Other _____	☐ 1 Vial ☐ 4 PFS / Pens ☐ _____ Refills_____

☐ OTEZLA®	DIRECTIONS	QUANTITY
☐ Starter/Titration Pack	(Use Otezla START form for bridge dosage) Starter: ☐ Take as directed on Starter Pack	☐ Starter Pack
☐ 30mg Tablet	Maintenance Treatment (30mg) ☐ Take 1 tablet by mouth TWICE a day ☐ Take 1 tablet by mouth ONCE a day ☐ Other: _____	☐ 30 ☐ 60 ☐ _____ Refills_____

☐ REMICADE®	DIRECTIONS	QUANTITY
☐ 100mg/20ml Vial	Starter: Administer _____mg kg at 0,2, and 6 weeks, then maintenance dosing Maintenance: ☐ Administer _____mg/kg every_____ weeks ☐ Other: _____	☐ _____ Vials Refills_____

☐ RINVOQ®	DIRECTIONS	QUANTITY
☐ 15mg ER tablet	☐ Take 1 tablet PO once daily ☐ Other: _____	☐ 30 Refills_____

☐ SIMPONI®	DIRECTIONS	QUANTITY
☐ 50mg/0.5ml SmartJect® (Pen) ☐ 50mlg/0.5ml PFS	☐ Inject 50mg SC once a month ☐ Other: _____	☐ 1 Refills_____

☐ SIMPONI™ ARIA®	DIRECTIONS	QUANTITY
☐ 50mg/4ml vial	Starter: ☐ Infuse _____mg (2mg/kg) IV at weeks 0 and 4, then maintenance dosing. Maintenance: ☐ Infuse _____mg (2mg/kg)IV every 8 weeks. ☐ Other: _____	☐ _____Vials Refills_____

☐ STELARA®	DIRECTIONS	QUANTITY
☐ 45mg/0.5ml PFS ☐ 90mg/1ml PFS	Starter: ☐ Inject 1 PFS SC on Day 1 Maintenance: ☐ Inject 1 PFS 4 weeks after start of treatment, then every 12 weeks thereafter ☐ Other: _____	☐ 1 Refills_____

☐ TALTZ®	DIRECTIONS	QUANTITY
☐ 80mg PFS ☐ 80mg Pen	Psoriatic Arthritis: Starter: ☐ Inject 160mg (2 pens/PFS) SC at week 0, followed by 80mg (1 pen/PFS) SC every 4 weeks ☐ Other: _____ Maintenance: ☐ Inject 80mg SC every 4 weeks	☐ 1 Pen / PFS ☐ 2 Pen / PFS ☐ _____ Refills_____

☐ XELJANZ®	DIRECTIONS	QUANTITY
☐ 5mg Tablet	☐ Take 5mg PO twice daily	☐ 60 | Refills____

☐ XELJANZ XR®	DIRECTIONS	QUANTITY
☐ 11mg Tablet	☐ Take 1 tablet PO once daily	☐ 30 | Refills____

GOUT AGENTS ☐ KRYSTEXXA®	DIRECTIONS	QUANTITY
☐ 8mg/ml Vial	☐ Administer 8mg via iv infusion over 2 hours every 2 weeks: ☐ Other: _____	☐ 2 vials Refills_____

INJECTION TRAINING ☐ Patient has received injection training ☐ Physician Office to provide injection training ☐ Pharmacy to provide injection training

PRESCRIBER INFORMATION

Prescriber's Name: _____ Contact Person: _____
Telephone: _____ Fax: _____ Email: _____
Office Address: _____ City: _____ State: _____ Zip: _____
NPI # : _____ DEA # : _____ TAX ID # : _____ Medicaid Provider # : _____

_____ _____ * _____
PRESCRIBER'S SIGNATURE (DATE) *IF BRAND DRUGS ARE PREFERRED, HANDWRITE **"BRAND MEDICALLY NECESSARY"** ABOVE

I authorize the Pharmacy noted above and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

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Encore 83
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