elixir
SPECIALTY PHARMACY

Rheumatology Enrollment Form
Fax: 877-309-0687 Call: 877-437-9012

☐ New to Therapy
☐ Current Therapy

Customer Information

Customer Name: _____

Date of Birth: _____ Gender: Male ☐ or Female ☐

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-mail: _____

Please attach copy of front and back of customer's insurance card(s)

Insurance Company Name: _____

Insurance Company Phone: _____

Policy holder: _____

Policy holder Employer: _____

Relationship to Customer: _____

ID# _____ Group# _____

RxBIN: _____ RxPCN: _____

Prescriber Information

Practice/ Organization Name: _____

Physician Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone#: _____ Fax#: _____

DEA# _____ NPI# _____

License#: _____ Medicaid UPIN#: _____

Physician Specialty: _____

Date Shipment Needed: _____

Ship to: ☐**Patient** ☐**Prescriber** ☐**Infusion Clinic**

Shipment Address: _____

Attn: _____

City: _____ State: _____ Zip: _____

If shipped to the physician's office, physician accepts on behalf of patient for administration in office.

Clinical Information and Prescription

Diagnosis and Clinical Information:

☐M06.9 Rheumatoid Arthritis ☐M45.9 Ankylosing Spondylitis ☐L40.59 Psoriatic Arthritis
☐M08.01 Juvenile chronic polyarthritis ☐Other: _____
Date of Diagnosis or Years with Disease: _____ Patients Allergies: _____
Patient Weight: _____ kg / lbs Patient Height: _____ cm / in
Has the patient had a NEGATIVE tuberculin skin test? ☐ Yes ☐ No
Is the patient a carrier of the Hepatitis B virus? ☐ Yes ☐ No Latex allergy: ☐ Yes ☐ No
Prior DMARD's and length of treatment: _____
Expected First Dose Date: _____ Injection training needed: ☐ Yes ☐ No

☐ **Actemra®** (tocilizumab) ☐ 162 mg SC syrinige ☐ 162 mg SC ACTPen ☐ 20mgml **IV** vial (patient weight needed)
Inject 162 mg **SC** ☐ once weekly (>/= 100 kg) OR ☐ every other week (<100 kg) Infuse _____ mg/kg **IV** every 4 weeks as directed

☐ **Cimzia®** (certolizumab pegol)
Initial Dose: ☐400mg SC @ 0, 2, 4 weeks prefilled syringe OR ☐400mg SC @ 0, 2, 4 weeks lyophilized powder vial (in office)
Maintenance Dose: ☐ 400mg SC every 4 weeks ☐200mg SC every 2 weeks ☐Prefilled Syringe ☐Vial

☐ **Enbrel®** (etanercept) Dose: ☐ 50mg SureClick ☐ 50mg Prefilled Syringe ☐ 25mg Prefilled Syringe ☐ 25mg Vial
Dispense: ☐ Inject SC once per week ☐Inject SC twice per week ☐ (JIA) inject 0.8mg/kg, max 50mg/week

☐ **Humira®** (adalimumab) Dose: ☐40mg Pen Auto Injector ☐40mg Prefilled Syringe ☐ Citrate/buffer free formulation
☐ 20 mg Prefilled Syringe ☐10mg Prefilled Syringe
Dispense: ☐ Inject SC once every other week ☐ Inject SC once per week ☐Other:

☐ **Kevzara®** (sarilumab) Inject SC once every 2 weeks ☐ Prefilled Syringe OR ☐ Prefilled Pen
Dose: ☐ 150mg/1.14ml ☐ 200mg/1.14ml

☐ **Olumiant®** (baricitinib) 2 mg PO once daily

☐ **Orencia®** (abatacept) ☐ Inject 125mg Prefilled Syringe **SC** once weekly
☐ Infuse **IV** over 30 minutes every 2 weeks for 3 doses. Starting at week 8, infuse over 30 minutes every 4 weeks
☐500mg (pat. <60kg) ☐750mg (60-100kg) ☐1000mg (>100kg) ☐10mg/kg if less than 75kg (JA)

☐ **Remicade®** (infliximab) OR ☐**Inflectra®** OR ☐**Renflexis®** Infuse IV over 2 hours as directed
Dose: ☐3mg/kg @ 0, 2, 6 weeks ☐3mg/kg every 8 weeks ☐5mg/kg @ 0, 2, 6 weeks then every 6 weeks thereafter (Ankyl Spon.)
☐10mg/kg @ 0, 2, 6 weeks then every 6 weeks thereafter ☐Other dosing: _____

☐ **Rinvoq®** (upadacitinib) 15 mg PO once daily

☐ **Rituxan®** (rituximab) Infuse 1000mg IV bolus on day 1 and 15 every 6 months.

☐ **Simponi®** (golimumab) Inject SC once per month
☐ 50mg SmartJect™ OR ☐ 50mg prefilled syringe

☐ **Simponi Aria®** (golimumab)
Infuse 2 mg/kg IV over 30 minutes; repeat dose at week 4 and then every 8 weeks thereafter

☐ **Xeljanz®** (tofacitinb) 5 mg PO twice daily

☐ **Xeljanz XR®** (tofacitinib) 11 mg PO once daily

Quantity Prescribed: ☐QS 30 days ☐Other: ____ **Refills Authorized:** ☐ 0 ☐1 ☐2 ☐3 ☐ 6 ☐1 yr ☐Other:____

Physician Signature (no stamps): _____ **Date:** _____