RHEUMATOID ARTHRITIS ENROLLMENT & PRESCRIPTION FORM

PHONE: 800-641-8475 **FAX:** 800-530-8589 **WEB:** www.HealthDyneSpecialty.com

To submit a new prescription via eRx, use NPI 1902298805. Faxed prescriptions will only be accepted from prescribing practitioners. Patients may not submit prescriptions via fax and must submit original copies in person or via the mail. Prescribers are reminded patients may choose any pharmacy of their choice.

PATIENT INFORMATION

Patient: _____ Caregiver: _____

DOB: _____ ☐ Male ☐ Female Weight: _____ ☐ kgs or ☐ lbs (check one) Height: _____ ☐ in or ☐ cm (check one) Recorded Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Best Phone #:_____ ☐ Cell Alternate Phone #:_____ ☐ Cell Email:_____

Allergies: _____ Latex Allergy: ☐ Yes ☐ No

ICD-10 Code for requested therapy: _____ ICD-10 Code(s) for other medical conditions: _____

MEDICAL ASSESSMENT

PLEASE FAX COPY OF ALL INSURANCE CARDS (FRONT & BACK) INCLUDING MEDICAL AND PRESCRIPTION

☐ Date of Diagnosis or Years with Disease: _____

PRIOR MEDICATIONS: ☐ Acetaminophen, ibuprofen, naproxen, aspirin ☐ Humira ☐ Enbrel ☐ Methotrexate ☐ Corticosteroids ☐ Celebrex ☐ Indocin ☐ Azulfidine ☐ Other meds tried: _____ Add'l justification for med: _____

CURRENT MEDICATIONS: _____ Is patient also taking methotrexate? ☐ Yes ☐ No

Date of Negative TB Test: _____ Hep B ruled out: ☐ Yes ☐ No If no, treatment started?: ☐ Yes ☐ No

PLEASE PROVIDE ALL CLINICAL INFORMATION INCLUDING LAB RESULTS ON ALL FORMS

PRESCRIPTION INFORMATION

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
Actemra®	☐ 162 mg/0.9 mL Prefilled Syringe ☐ Actemra Actpen 162 mg/0.9 mL	☐ 162 mg Sub-Q every other week ☐ 162 mg Sub-Q once a week	☐ 2 PFS/pens ☐ 4 PFS/Pens	_____
Cimza®	Starter Dose: ☐ Starter Kit (200 mg prefilled Syringes)	☐ 400mg Sub-Q at weeks 0, 2, and 4	☐ 1 Kit = 6 x 200 mg/mL PFS ☐ 3 Kits = 3 cartons of 2 x 200 mg vials	_____
	Maintenance Dose: ☐ 200mg/mL Prefilled Syringe ☐ 200mg Lyophilized Vial	☐ 400mg Sub-Q every 4 weeks ☐ 200mg Sub-Q every 2 weeks	☐ 1 Carton = 2 x 200 mg/mL PFS ☐ 1 Carton = 2 x 200 mg vials	_____
Enbrel®	☐ 50mg/mL Sureclick™ ☐ 50mg/mL Prefilled Syringe ☐ 25mg Vial (inj. supplies incl) ☐ 25mg/mL Prefilled Syringe ☐ Enbrel Mini Cartridge 50mg/mL	☐ Inject 50mg Sub-Q ONCE a week ☐ Inject 25mg Sub-Q TWICE a week _____	☐ 1 Kit (weekly dosing) ☐ 2 Kits (twice weekly dosing)	_____
Humira®	☐ 40mg/0.8mL PEN ☐ 40mg/0.8mL Prefilled Syringe ☐ 40mg/0.4mL PEN (Citrate Free) ☐ 40mg/0.4mL Prefilled Syringe (Citrate Free) ☐ 20mg/0.2mL Prefilled Syringe (Citrate Free) ☐ 10mg/0.1mL Prefilled Syringe (Citrate Free) ☐ 10mg/0.2mL Prefilled Syringe ☐ 20mg/0.4mL Prefilled Syringe ☐ 80mg/0.8mL PEN	☐ Inject 40mg Sub-Q every OTHER week ☐ Inject 40mg Sub-Q ONCE a week ☐ 80mg Sub-Q every OTHER week.	☐ #_____ of PFS ☐ #_____ of Pens	_____
Kevzara®	☐ 150mg/1.14mL Pen ☐ 150mg/1.14mL Prefilled Syringe ☐ 200mg/1.14mL Pen ☐ 200mg/1.14mL Prefilled Syringe	☐ 150mg Sub-Q every 2 week ☐ 200mg Sub-Q every 2 weeks	☐ 2 Pens ☐ 2 PFS	_____
Olumiant®	☐ 1mg ☐ 2mg	☐ 1 tablet by mouth once daily ☐ 1 tablet by mouth once daily	☐ 30 ☐ 30	_____
Orencia®	☐ 250mg Vial (IV use only)	☐ _____ mg/kg IV every month	☐ 2 Vials ☐ 3 Vials ☐ 4 Vials	_____
	☐ 125mg/mL Prefilled Syringe ☐ 250mg Vial (IV use only) ☐ 125mg/mL Clickject PEN ☐ 50mg/0.4mL Prefilled Syringe ☐ 87.5mg/0.7mL Prefilled Syringe	☐ 125mg Sub-Q ONCE a week ☐ _____ mg IV infusion over 30 minutes every 2 weeks for 3 doses (i.e., a dose at weeks 0, 2, and 4). Starting at week 8, give _____ mg IV infusion over 30 minutes every 4 weeks.	☐ #_____ of PFS ☐ #_____ of Pens ☐ #_____ of Vials	_____
Otrexup®	☐ 10mg/0.4mL Autoinjector ☐ 12.5mg/0.4mL Autoinjector ☐ 15mg/0.4mL Autoinjector ☐ 17.5mg/0.4mL Autoinjector ☐ 20mg/0.4mL Autoinjector ☐ 22.5mg/0.4mL Autoinjector ☐ 25mg/0.4mL Autoinjector ☐ 7.5mg/0.4mL Autoinjector	☐ 1 Autoinjector one time weekly	☐ 4 Autoinjectors	_____

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MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
Rasuvo®	_____	☐ 1 Autoinjector one time weekly	☐ 4 Autoinjectors	_____
Remicade®	☐ 100 mg Lyophilized Vial(s)	☐ _____ mg/kg IV every two months ☐ Starter doses: _____ mg/kg IV at 0,2, and 6 weeks for induction ☐ Every 6 weeks (5mg/kg q 6 weeks)	☐ _____ Vial(s)	_____
Rinvoq®	☐ 15mg ER Tablet	☐ Take 1 tablet by mouth once daily	☐ 30	_____
Rituxan®	☐ 100mg/10mL Vial ☐ 500mg/10mL Vial	☐ 1000mg IV on days 1 and 15 every _____ weeks	☐ _____ Vial(s)	_____
Simlandi®	☐ 40mg/0.4mL (PEN) ☐ 40mg/0.4mL (PFS)			_____
Simponi®	☐ 50 mg/0.5mL SmartJect™ ☐ 50 mg/0.5mL Prefilled Syringe	☐ Inject 1 dose (50mg) Sub-Q once monthly	☐ 1 (one)	_____
Simponi® Aria™	Starter Dose: ☐ 50mg (4mL) Vial(s)	☐ 2 mg/kg IV infusion over 30 min at week 0	☐ _____ Vial(s)	_____
	Maintenance Dose: ☐ 50mg (4mL) Vial(s)	☐ 2 mg/kg IV infusion over 30 min at week 4 and every 8 weeks thereafter	☐ _____ Vial(s)	_____
Truxima®	☐ 100mg/10mL Vial ☐ 500mg/50mL Vial	☐ 1000mg IV on days 1 and 15 every _____ weeks	☐ _____ Vial(s)	_____
Xeljanz®	☐ 5 mg tablet ☐ XR 11mg	☐ Take 1 tablet by mouth twice daily ☐ Take 1 tablet by mouth one time daily	☐ 60 Tablets ☐ 30 Tablets	_____ _____
Other				

INJECTION TRAINING: OFFICE TO COORDINATE HEALTHDYNE SPECIALTY TO COORDINATE

PRESCRIBER INFORMATION

Anticipated Start Date: _____ Prescriber Specialty: _____

Ship to: ☐ Patient ☐ Physician ☐ Clinic ☐ Other: _____

Fax #: _____ Contact Name: _____

Office Address: _____ City: _____ State: _____ Zip: _____

The terms and conditions posted at www.HealthDyneSpecialty.com have been read by the person signing this form and are incorporated into this document by reference. The data privacy terms posted at www.HealthDyneSpecialty.com have been read by the person signing this form and are incorporated into this document by reference.

☐ I understand that HealthDyne Specialty may transfer this prescription to another pharmacy as an agent of the prescriber if unable to dispense.

Prescriber's Name: _____ Prescriber's Signature: _____ Date: _____

☐ Use substitution ☐ Dispense as written