ENVISIONSPECIALTY

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

☐New to Therapy
☐Current Therapy

Patient Information

Patient 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 patient's insurance card(s)

Insurance Company Name: ______________________

Insurance Company Phone: ______________________

Policy holder: ______________________

Policy holder Employer: ______________________

Relationship to Patient: ______________________

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.

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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
Inject 162 mg **SC** ☐ once weekly (>/= 100 kg) OR ☐ every other week (<100 kg)

☐ 20mgml **IV** vial (patient weight needed)
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:** __________