Rheumatology(A-O)

Actemra®, Benlyst®, Cimzia®, Cosentyx®, Enbrel®, Humira®, Orencia®, Otezla®, Otrexup®

Specialty Pharmacy Services Enrollment Form

Phone: (844) 431-7277

Fax: (844) 432-7277

New York Prescribers, please submit an electronic prescription together with the Enrollment Form

For pharmacy locations, please scan QR code

PATIENT INFORMATION

Patient's Name:	Last 4 Digits of SS#:	DOB: / /	Sex: O M O F	Weight:	Height:	Diabetic: O Y O N
Address:		Allergies:				
City:	State:	Zip:	Home Phone: ( )		Work or Cell: ( )	
HIPAA Contact:	Emergency #: ( )				Interpreter Needed: O Y O N	

PRESCRIBER INFORMATION

Prescriber Name:	O MD O DO O NP O PA	NPI:	
Office Contact:	Supervising Physician, if applicable:		
Address:	City:	State:	Zip:
Phone:	Fax:		

INSURANCE INFORMATION | PLEASE SEND COPY OF INSURANCE CARD

Primary Insurance:	Policy ID:	Group #:	
Policyholder Name:	Policyholder DOB: / /	BIN:	PCN:

CLINICAL INFORMATION | PLEASE SEND COPY OF PROGRESS NOTES AND LAB REPORTS SUPPORTING DIAGNOSIS

Diagnosis: O M06.9 Rheumatoid Arthritis, unspecified O M45.9 Ankylosing Spondylitis O M08.0 Juvenile Idiopathic Arthritis O L40.59 Psoriatic Arthritis

O L40.54 Juvenile Psoriatic Arthritis O M06.9 Rheumatoid Arthritis, unspecified O H20 Iridocyclitis (Uveitis) O Other: _____

Date of Diagnosis: / /	Date of Negative TB Test: / /	Any prior treatment: O Yes O No (provide information below)	Desired Start Date: / /

Prior Therapy:	Reason for Discontinuation of Therapy:	Approximate Start Date:	Approximate End Date:
Comorbidities:	Concomitant Medications:	Deliver Meds: O Home O Doctor's Office	

PRESCRIPTION INFORMATION

Medication	Dose/Strength	Sig	Quantity	Refills
O ACTEMRA® (vials will be used to fill dose)	O 80mg/4ml Vials O 200mg/10ml Vials O 400mg/20ml Vials O PFS 162mg/0.9ml (box of 4)	O Dosage: Patients<100kg (220 lbs) 162mg (sc) every other week followed by an increase to every week based on clinical response O Dosage: Patients>100kg (220lbs) 162mg (sc) every week O Initial Dose: Infuse 4mg/kg _____mg IV over 60 minutes every 4 weeks O Maintenance Dose: 8mg/kg _____mg IV over 60 minutes every 4 weeks O Other Regimen:	28 Day Supply	
O BENLYSTA®	O 120mg Vial O 400mg Vial	O Infuse _____mg/kg in 250NS over 2hrs at week 0, 2, 6 and then every 8 wks	QS for each Injection	
O CIMZIA®	O PFS Starter Kit (6 Syringes) O PFS 200mg/ml Kit (2 Syringes) O 400mg Lyophilized Powder	O Inject 400mg SQ at weeks 0, 2, and 4 O Inject 400mg SQ every 4 weeks O Inject 200mg SQ every 2 weeks	28 Day Supply	
O COSENTYX 150mg/ml (qty 1)	O Sensoready Pen O PFS O Lypholized Powder Vial	O Inject 150mg SQ at weeks 0, 1, 2, 3, and 4 then every 4 weeks thereafter O Inject 150mg SQ every 4 weeks O Inject 300mg (Qty 2) SQ every 4 weeks	28 Day Supply	
O ENBREL® O SureClick® O PFS O Vials	O 1 carton (4 x 50mg/ml) O Other:	O Inject 50 mg SQ every week O Other Regimen:	28 Day Supply	
O HUMIRA® O Pen O PFS	O 40mg (box of 2)	O Inject 1 pen SQ (40mg) every 14 days O Inject 1 pen (40mg) SQ once a week	28 Day Supply	
O HUMIRA® O Pen O PFS (Uveitis)	O Psoriasis/Uveitis Starter Kit (4 x 40mg/0.8ml) O 1 carton (2 x 40mg/0.8ml)	O Inject 2 pens (80mg) SQ on Day 1, then 1 pen (40mg) on Day 8, then 1 pen on Day 22 O Inject 1 pen (40mg) SQ every other week	28 Day Supply	
O ORENCIA® O Vials O PFS O Clickject	Weight & Dose: O 125mg (box of 4) O 0–60kg = 500mg (2 Vials) O 60–100kg = 750mg (3 Vials) O >100kg = 1000mg (4 Vials)	O Infuse _____mg IV in 100ml NS over 30 minutes on week 0, 2, 4 and then every 4 weeks O Inject 125mg SQ within 1 day of Orencia infusion, then 125mg SQ once a week O Inject 125mg SQ once a week (without loading dose)	28 Day Supply	
O OTEZLA®	O 30mg TITR Starter Pak (28 day supply) O 30mg po BID (30 day supply)	O Take as directed on package O Take 1 tablet po BID	O 28 Day Supply O 30 Day Supply	
O OTREXUP™ Autoinjector (box of 4)	O 7.5mg/0.4ml O 20mg/0.4ml O Other: O 10mg/0.4ml O 25mg/0.4ml	O Inject _____mg SQ once a week	28 Day Supply	
O Other:				

Additional Instructions:

INJECTION TRAINING

O Patient received injection training O Prescriber's office to provide injection training O Price Chopper Specialty to coordinate injection training

By signing this form and utilizing our services, you are authorizing Price Chopper Specialty to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber Signature: Date Issued: / /	Prescriber Signature: Date Issued: / /
Substitution Permitted	Dispense as Written

Interchange is mandated unless the practitioner indicates 'Dispense as Written' or 'No Substitution' in accordance with the law.