Rheumatology(P-Z)

Rasuvo®, Remicade®, Rituxan®, Simponi®, Simponi Aria®, Stelara®, Xeljanz®, Xeljanz XR®

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: M F	Weight:	Height:	Diabetic: Y N
Address:		Allergies:				
City:	State:	Zip:	Home Phone: ( )		Work or Cell: ( )	
HIPAA Contact:		Emergency #: ( )			Interpreter Needed: Y N	

PRESCRIBER INFORMATION

Prescriber Name:	MD DO NP 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: M06.9 Rheumatoid Arthritis, unspecified | M45.9 Ankylosing Spondylitis | M08.0 Juvenile Idiopathic Arthritis | L40.59 Psoriatic Arthritis

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

Date of Diagnosis: / /	Date of Negative TB Test: / /	Any prior treatment: Y N (provide information below)	Desired Start Date: / /

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

PRESCRIPTION INFORMATION

Medication	Dose/Strength	Sig	Quantity	Refills
RASUVO® Autoinjector (box of 4)	7.5mg/.15ml 20mg/.4ml 10mg/.20ml 25mg/.5ml Other:	Inject _____mg SQ once a week	28 Day Supply	
REMICADE®	Exact Dose Round dose up/down to nearest 100mg	Infuse _____mg/kg in 250NS over 2hrs at week 0, 2, 6 and then every 8 weeks. Other Regimen: _____ **Titrated infusion rate will be used unless otherwise noted: 10ml/hr x 15min; 20ml/hr x 15min; 40ml/hr x 15min; 80ml/hr x 15min; 150ml/hr x 30 min*	QS for each Infusion	
RITUXAN®	500mg Vial x2	Infuse 1000mg IV over 4–6 hrs on day 1 and 15 (given in combination with MTX)	4 Vials	
SIMPONI®	50mg/0.5ml PFS 50mg/0.5ml Autoinjector	Inject 50mg SQ ONCE a month	QS for each Infusion	
SIMPONI ARIA™	50mg/4ml Vial	Infuse _____mg IV over 30 min at weeks 0 and 4, then every 8 weeks	4-Week Supply	
STELARA® Eligible for self-injection: Yes No	45mg/0.5ml (≤100kg) 90mg/1ml (>100kg)	Starter: Inject 45mg/0.5 ml Sub-Q on Day 1 Inject 90mg/1ml Sub-Q on Day 1 Maintenance: 45mg/0.5ml Sub-Q on Day 29 and every 12 weeks thereafter Maintenance: 90mg/1ml Sub-Q on Day 29 and every 12 weeks thereafter	1 PFS	
ELJANZ®	5mg Tab	Take 5mg by mouth TWICE daily	30 Day Supply	
XELJANZ® XR	11mg Tab	Take 11mg by mouth once daily	30 Day Supply	
OTHER				

Additional Instructions:

INJECTION TRAINING

Patient received injection training | Prescriber's office to provide injection training | 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.