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.

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) ☐Inject 162 mg **SC** every week (>/= 100 kg) ☐Inject 162 mg **SC** every other week (<100 kg)
☐Infuse _____ mg/kg **IV** over 1 hour every 4 weeks

☐ **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 (Ankylosing Spon.)
☐10mg/kg @ 0, 2, 6 weeks then every 6 weeks thereafter ☐Other dosing: _____

☐ **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:**_____