

Rheumatology Enrollment Form Fax: 949-340-8008

Phone: 949-305-0788

Prescriber Name Defection Name City, State, 2 p Home Phone Dos. Last Four of Ss. Mobile Phone First Contact Person First Contact Person The Plant Contact Person Discrete Park Contact Person The Plant Contact Person Discrete Park Discret		INFORMATI		PRESCRIBER INFORMATION										
Address 2 City, State, 2ip	Please complete the following or send patient demographic sheet													
DEA	Patient Na	me		Prescriber Name										
NPI				DEA										
Address	Address 2			NDT	NPT									
Language Preference Contact Person	City, State	, Zip												
Language Preference Contact Person	Home Pho	ne	Mobile Phone											
Language Preference Contact Person	DOB	Last Fo	our of SSGender	Phone Fax										
Clinical Diagnosis places (ax or email relevant clinical notes), also cests, and previous medical history to expedite prior authorization Dagnosis of Poers with Disease Signature Prior historient Date: Bit Poers Signature Milliand Signature Prior historient Date: Bit Poers Signature Milliand Signature Prior historient Date: Bit Poers Signature Milliand Signature Milliand Signature Milliand Signature Signatu	Language	Preference		Contact Person	Contact Person									
Diagnosis Co 10: Prior Treatment Date: Prior Treatment Date: Type Prior Treatment Date: Spetiant Current of the previously treated? 3" 2 in Will patient terminate current therapy upon start of new prescription? 2" 2" N Will patient terminate current therapy upon start of new prescription? 2" 2" N PRESCRIPTION INTORNATION PRESCRIPTION INTORNATION INTORNATION PRESCRIPTION INTORNATION INTORNATION INTORNATION PRESCRIPTION INTORNATION INTORNATION INTORNATION INTORNATION INTORNATION	Clinical Diagnosis: please fax or email relevant clinical notes, labs, tests, and previous medical history to expedite prior authorization													
Date of Diagnosis or Years with Disease	Diagnosis / ICD 10: Prior Treatment Date: TB/PPD Test □ Yes □ No Results													
Process							cm/in							
Type	Has patient	been previously			n start of new prescription	n? □ Y □ N								
Clmzia	_					0 11	D CII							
Cimza	Type	Medication	Dose/Strength			Quantity								
2		- Cimzia				□ 4-wook								
Part		Cirrizia	2 x 200mg Fremied Syninge											
Entire			□ 25mg Prefilled Syringe	☐ Inject 25mg twice weekly. 72	-96 hours apart		□1□2□3□4□5							
Blocker Humina G		□ Enbrel		□ Inject 50mg SQ once weekly	·	□ 4-week	□ 11 □							
Blocker	TNF		□ 50mg Prefilled Syringe	□ Other		supply								
Humia GF Ghong/O, 4m Perilled Syringe Exprises Starter Pack Inject 40mg overy other week thereafter Inject 160mg 90 on day 15 In				☐ Inject 40mg SQ every other we	eek		□ 1 □ 2 □ 3 □ 4 □ 5							
Beariasis Starter Pack Crohm's Starter Pa				□ Inject 40mg SQ once weekly			□ 11 □							
Infectra		□ Humira CF												
Infectra				then inject 40mg every other	week thereafter									
Inflectra			□ Cronn's Starter Pack	then start maintenance dose	n inject 80mg on day 15									
Remicade		□ Inflectra	□ 100mg/20 ml vial				□1 □ 2 □ 3 □ 4 □ 5							
Remicade 100mg/ 20 ml vial		2 1					□ 11 □							
Simponi		□ Remicade	□ 100mg/ 20 ml vial											
Somg/O.5ml Autoinjector 2mg/kg IV over 30 minutes at weeks 0 and 4,		- Simponi	□ 50mg/0 5ml Prefilled Syringe	<u> </u>										
Simponi		□ Simponi		Inject 30mg 3Q once a month										
Aria		□ Simponi		□ 2mg/kg IV over 30 minutes at	weeks 0 and 4,		_ 1 _ 2 _ 3 _ 4 _ 5							
162mg/0.9 ml PFS			J. 3	then every 8 weeks thereafter	•		□ 11 □							
Actemra														
Antagonist	TI 6	□ Actemra	□ 162mg/0.9 ml PFS	☐ Inject 1 syringe SQ once week	y r wook									
Bonng/A ml (20mg/ml) 20mg/s/John (20mg/s/John (20mg/ml) 20mg/s/John (20mg/s/John (20mg			TV infusion	1 Inject 1 Syringe SQ every other	I WEEK	supply								
Cosentyx		- / Accernia												
Val for further dilution prior to IV infusion			□ 200mg/10ml (20mg/ml)				<u></u>							
Revzara 150mg prefilled Syringe 200mg SQ once every 2 weeks 34 - 5 35 - 4														
200mg SQ once every 2 weeks supply 11		14	vial for further dilution prior to IV infusion	15000 500 0000 0000 2 0000 100	150 60		1 2 2 4 5							
1.17A		□ Kevzara					п 11 п							
1-17A Cosentyx 1-150mg/ml single-use prefilled syringe 150mg/ml single-use prefilled syringe 150mg SQ every 4 weeks 150mg SQ every 4 w						Зарріу								
Antagonist 300mg kyophilized powder in a single use vial for reconstitution 300mg SQ every 4 weeks 300mg SQ on day 1, then followed by 80mg every 4 4-week 31 3 3 4 5 5 5 5 5 5 5 5 5	IL-17A	□ Cosentyx		weeks thereafter	weeks thereafter									
Taltz	Antagonist	,	□ 300mg lyophilized powder in a single	□ 150mg SQ every 4 weeks										
80mg Auto-Injector (2 pens) 80mg SQ every 4 weeks 91 92 91 92 93 94 95 94 95 95 94 95 95														
Somg Auto-Injector (1 pen) Somg SQ every 4 weeks Supply		□ laltz			wea by 80mg every 4	_ 41.								
Bomg Prefilled Syringe (1 syringe) Inject SQ weeks 0,4, and every 12 weeks thereafter delta supply lil d							□ 11 □							
IL-12,23				a some sectory i weeks		Зарріу								
II-23	IL-12,23	□ Stelara	□ 45 mg Prefilled Syringe			□ 4-week	□1□2□3□4□5							
Antagonist														
Skyrizi 150 mg Pen 150 mg SQ at weeks 0 & 4 and every 12 weeks thereafter 150 mg every 12 weeks thereafter 150 mg every 12 weeks 125 mg/ml Prefilled Syringe Inject 125 mg SQ once weekly 125 mg/ml Clickjet Autoinjector (pen) Infusemg IV every 4 weeks 4-week 11 2 3 4 5 5 5 5 5 5 5 5 5		□ Tremfya												
T cell Costimulation Orencia 125 mg/ml Prefilled Syringe Infuse Inf	Antagonist	□ Skyrizi		150mg SO at weeks 0.8, 4 and	S avany 12		U 11 U							
T cell Co- stimulation Modulator		- Skyrizi			every 12									
stimulation Modulator			-	□ 150 mg every 12 weeks										
Modulator				,										
Ship to: Patient Office Other Date: Need by Date		□ Orencia		□ Infusemg IV every 4 we	eeks									
* Prescriber Authorization: I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s) and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorizations forms and the receipt and submission of patient tab values and other patient data, in the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize the pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network. Product Substitution permitted Dispense as Written Date:	rioddiatoi		250Hg/ 15HH viai (1V OHy)			Supply								
* Prescriber Authorization: I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s) and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorizations forms and the receipt and submission of patient tab values and other patient data, in the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize the pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network. Product Substitution permitted Dispense as Written Date:	Shin to:	Patient Office	□ Other	Date:	Need by Date									
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Prescriber's Signature:Date:	further authorize the pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.													
	□ Product Subs	sulution permitted	Dispense as Written											
CONFIDENTIALITY STATEMENT: This communication is intended for use of the individual or entity to which it is addressed and may contain information that is privileged, confidential, and exempt from disclosure under applicable law If the reader of this communication is not the intended recipient or the employee or	Prescriber's S	ignature:			Date:									



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	the following or send pat		nic sheet	PRESCRIBER INFOR	IATION							
Patient Name				Prescriber Name								
Address 2				DEA								
City, State, Zip)			NPIAddress								
Home Phone_	Mobile Ph	none		City, State, Zip								
DOB				Phone								
Language Prei	erence			Contact Person								
Clinical Diagnosis: please fax or email relevant clinical notes, labs, tests, and previous medical history to expedite prior authorization												
Diagnosis / ICD 10:			Prior Treatn	nent Date:	TB/PPD Test □ Yo	es No Results						
	s or Years with Disease	1	Is patient co	urrently on therapy? Y N	Weight	kg/lbs F	leight cm/in					
	n previously treated? \square Y \square N	Ň	Will patient	terminate current therapy upo		escription? \square Y \square N	N					
T-Score Results:			History of Fra	actures: ION INFORMATION								
Туре	Medication	Dose/Stre		Directions		Quantity	Refill					
CD 20-directed	□ Riabni	□100mg/10ml vial □500mg/50ml vial		o			- 11 - 5					
cytolytic antibody	□ Rituxan□ Ruxience						□ 11 □					
	□ Truxima											
PDE 4 inhibitor	□ Otezla	□ Starter Pack		☐ Take as directed		□ 1 pack	_ 1 _ 2 _ 3 _ 4 _ 5					
		□ 30mg tablets		□ Take 1 tablet PO twice daily		□ 60 tablets	0 11 0 <u> </u>					
JAK inhibitor	□ Olumiant	□ 2 mg tablets		□ Take 2mg PO once daily		□ 30 tablets	0102030405 0110					
57	□ Rinvoq	□ 15 mg tablets		□ Take 15mg PO once daily		□ 30 tablets	□1□2□3□4□5 □11□					
	□ Xeljanz	□ 5mg tablets		□ Take 5mg PO twice daily		□ 60 tablets	- 11 - 1 - 2 - 3 - 4 - 5 - 11 -					
	□ Xeljanz XR	□ 11mg tablets		□ Take 11mg PO once daily		□ 30 tablets	0 1 0 2 0 3 0 4 0 5 0 11 0					
	□ Forteo	□ 600 mcg/2.4 ml Prefilled		□ Inject 20 mcg SQ as directed once daily		□ 4-week	□ 1 □ 2 □ 3 □ 4 □ 5					
rhPTH (1-34)	□ BD Ultra Fine Pen Syringe Needles Syringe					supply	□ 11 □					
PTH1R agonist	□ Tymlos □ 80mcg Prefilled Syrii □ BD Ultra Fine Pen Needles		Syringe	□ Inject 80 mcg SQ once daily	□ 4-week supply	-1-2-3-4-5 -11						
RANK L inhibitor	□ Prolia	□ 60mg Prefilled Syringe		□ Inject 60mg SQ once every 6 months			0102030405 0110					
BLyS inhibitor	□ Benlysta	□ 120 mg/5ml single-dose vial □ 400mg/20ml single-dose		10mg/kg IV at 2-week intervals for the first 3 doses and at 4-week intervals thereafter		□ 4-week supply						
BLY3 ITITIDIO				doses and at 4-week intervals thereafter		Supply						
		vial 200mg/ml single	doso	□ 200mg SQ once weekly								
		prefilled autoing										
		 200mg/ml single-dose prefilled syringe 										
Interferon	□ Saphnelo	□ 300mg/2ml Sing		☐ Infuse 300mg intravenously	over 30 minutes	□ 4-week	_ 1 _ 2 _ 3 _ 4 _ 5					
Receptor		vial		every 4 weeks		supply	□ 11 □					
Antagonist, Type I Pegylated uric	□ Krystexxa	□ 8mg/ml vial		□ 8mg given as an intravenous	s infusion every 2		□ 1 □ 2 □ 3 □ 4 □ 5					
acid specific enzyme				week for chronic Gout			□ 11 □					
Bisphosphonate	□ Zoledronic Acid	□ 5mg in a 100 m infuse solution	l ready-to-	□ Infuse 5mg/100 ml IV over 3	30 minutes		_ 1 _ 2 _ 3 _ 4 _ 5 _ 11 _					
Corticosteroid	□ Rayos		2mg tablets				0102030405 0110					
Interleukin-1B	□ Ilaris	□ 150mg/mL sdv		☐ 4mg/kg SQ every 4 weeks		□ 4-week	- 1 - 2 - 3 - 4 - 5					
blocker Other						supply	- 11 - <u> </u>					
Other	D											
Ship to: Date: Need by Date												
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•	n permitted □ Dispense as Written		go si die product	production and production and the tri								
Prescriber's Signatu					Date:							
CONFIDENTIALITY STATEMENT: agent responsible for delivery of	This communication is intended for use of the individua the communication, you are hereby notified that any dis	al or entity to which it is addressed an esemination distribution, or copying of	d may contain information f the communication is str	n that is privileged, confidential, and exempt from disclosure rictly prohibited. If you have received this communication in e	under applicable law If the reader o error, please notify us immediately b	of this communication is not the int by telephone.	ended recipient or the employee or					
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