EPSRx A CarePartners Pharmacy Company | CarePartners Specialty Infusion

Phone : 844-800-5377 Fax : 214-782-9155

RHEUMATOLOGY ORAL/SQ RX ENROLLMENT FORM

Referral Date: | Ship to: ☐ Home ☐ Office ☐ Other _____

PATIENT INFORMATION

Patient Name: | Date of Birth: | Gender:

Home Phone: | Cell Phone: | Email:

Address: | City: | State: | Zip:

Emergency Contact: | Emergency Phone:

INSURANCE INFORMATION

Please fax copy of prescription and insurance cards with this form if available (front and back)

Prior Authorization Reference Number: _____

DIAGNOSIS

- ☐ M06.9 Rheumatoid Arthritis
- ☐ M08.0 Juvenile Rheumatoid Arthritis
- ☐ M45.9 Ankylosing Spondylitis
- ☐ L40.59 Psoriatic Arthritis
- ☐ Other: _____

Date of Diagnosis: _____

Other Conditions: _____

PRESCRIBER INFORMATION

Prescriber Name: _____

DEA #: _____ NPI #: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Contact Person: _____

CLINICAL INFORMATION

Patient Weight: _____ ☐ kg ☐ lbs

Allergies: _____

Current Medications: _____

CrCl: _____ Hepatitis B ruled out: ☐ Yes ☐ No

TB Test performed: ☐ Yes ☐ No Results: _____

Therapy ☐ New ☐ Reauthorization ☐ Restart

Prior Therapy: _____

Tx Response and Dates: _____

☐ Pharmacy to coordinate home health nursing visit and/or nursing training

☐ Patient already trained on subcutaneous infusion

PRESCRIPTION INFORMATION

RX to include diluents, needles, syringes, ancillary supplies, home medical equipment to administer infusion.

Medication	Strength	Dose and Directions	Quantity	Refills
☐ Abrilada®	☐ 40mg/0.8mL Pen ☐ 40mg/0.8mL Syringe	☐ Inject 40mg/0.8mL Pen SQ every week ☐ Inject 40mg/0.8mL Syringe SQ every other week		
☐ Actemra®	☐ 162mg/0.9mL Pen ☐ 162mg/0.9mL PFS	☐ Patients weighing <100kg: Inject 162mg SQ once every other week. ☐ Patients weighing ≥100kg: Inject 162mg SQ once every week.		
☐ Amjevita®	☐ 40mg/0.8mL Pen ☐ 40mg/0.8mL Syringe	☐ Inject 40mg/0.8mL SQ every week ☐ Inject 40mg/0.8mL SQ every other week		
☐ Cimzia®	☐ 200mg/mL PFS ☐ 200mg/mL Vial	☐ Loading Dose: Inject 400mg SQ at weeks 0, 2, and 4. ☐ Maintenance Dose: Inject 400mg SQ every 4 weeks. ☐ Maintenance Dose: Inject 200mg SQ every 2 weeks.		
☐ Cosentyx®	☐ 150mg/mL PFS ☐ 150mg/mL Pen ☐ 150mg/mL PFS (2 Pack) ☐ 150mg/mL Pen (2 Pack)	☐ Loading Dose: Inject 150mg SQ at weeks 0, 1, 2, 3, and 4. ☐ Loading Dose: Inject 300mg SQ at weeks 0, 1, 2, 3, and 4. ☐ Maintenance Dose: Inject 150mg SQ every 4 weeks. ☐ Maintenance Dose: Inject 300mg SQ every 4 weeks.		
☐ Cyltelzo®	☐ 40mg/0.8mL Pen ☐ 40mg/0.8mL Syringe	☐ Inject 40mg/0.8mL SQ every week ☐ Inject 40mg/0.8mL SQ every other week		
☐ Other: _____				

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☐ Enbrel®	☐ 25mg/0.5mL PFS ☐ 25mg/0.5mL vial ☐ 50mg/mL PFS ☐ 50mg/mL SureClick Autoinjector	☐ Inject 25mg SQ twice weekly. (72-96 hours apart) ☐ Inject 50mg SQ once a weekly.		
☐ Hadlima®	☐ 40mg/0.4mL Pen ☐ 40mg/0.4mL PFS ☐ 40mg/0.8mL Pen ☐ 40mg/0.8mL PFS	☐ Inject 40mg SQ every week. ☐ Inject 40mg SQ every other week.		
☐ Humira®	☐ 20mg/0.4mL PFS CF ☐ 40mg/0.8mL Pen CF ☐ 40mg/0.8mL PFS CF	☐ Inject 20mg SQ every other week. ☐ Inject 40mg SQ every week. ☐ Inject 40mg SQ every other week.		
☐ Hyrimoz®	☐ 40mg/0.4mL Pen ☐ 40mg/0.4mL Syringe	☐ Inject 40mg SQ every week ☐ Inject 40mg SQ every other week		
☐ Ilaris®	☐ 150mg/mL Injection SDV	☐ Inject _____ mg SQ every _____ weeks. ☐ Inject 4mg/kg SQ every 4 weeks. (300mg/dose maximum)		
☐ Kevzara®	☐ 150mg/1.14mL Pen ☐ 150mg/1.14mL PFS ☐ 200mg/1.14mL Pen ☐ 200mg/1.14mL PFS	☐ Inject 150mg SQ every 2 weeks ☐ Inject 200mg SQ every 2 weeks		
☐ Olumiant®	☐ 1mg Tablet	☐ Take 1mg tablet orally once daily		
	☐ 2mg Tablet	☐ Take 2mg tablet orally once daily as monotherapy or in combination.		
☐ Orencia®	☐ 125mg Pen ☐ 125mg PFS ☐ 250mg vial ☐ Other: _____	☐ Inject 200mg SQ every 2 weeks. ☐ Inject 125mg SQ every 2 weeks.		
☐ Otezia®	☐ Titration Starter Pack for 30mg BID dosage	☐ Five (5) day titration period: Day 1: Take 10mg PO in the morning. Day 2: Take 10mg PO in the morning and 10mg PO in the evening. Day 3: Take 10mg PO in the morning and 20mg PO in the evening. Day 4: Take 20mg PO in the morning and 20mg PO in the evening. Day 5: Take 20mg PO in the morning and 30mg PO in the evening. Day 6 and thereafter: 30 mg PO twice daily.		
	☐ 30mg tablet	☐ Maintenance Dose: 30mg orally twice daily.		

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Medication	Strength	Dose and Directions	Quantity	Refills
☐ Rinvoq®	☐ 15mg Oral Tablet	☐ Take one tablet orally once daily with or without food.		
☐ Skyrizi®	☐ 150mg/mL Pen ☐ 150mg/mL PFS	☐ Inject 150mg SQ at Week 0. ☐ Inject 150mg SQ every 12 weeks starting at Week 4.		
☐ Simponi®	☐ 50mg/0.5mL Autoinjector ☐ 50mg/0.5mL PFS ☐ 100mg/0.5mL PFS	☐ Inject 50mg SQ once a month. ☐ Other: _____		
☐ Stelara®	☐ 45mg/0.5mg PFS ☐ 50mg/0.5mL PFS ☐ 100mg/0.5mL PFS	☐ Loading Dose: Inject 45mg SQ on Day 1. ☐ Loading Dose: Inject 90mg SQ on Day 1. ☐ Loading Dose: Inject 45mg SQ every 12 weeks. ☐ Loading Dose: Inject 90mg every 12 weeks. ☐ Maintenance Dose: Inject 90mg SQ on Day 29 and every 12 weeks after.		
☐ Taltz®	☐ 80mg/mL Pen ☐ 80mg/mL PFS	☐ Loading Dose: Inject 160mg (2 injections of 80mg) once SQ on week 0. ☐ Maintenance Dose: Inject 80mg once SQ every 4 weeks.		
☐ Tremfya®	☐ 100mg/mL PEN ☐ 100mg/mL PFS	☐ Loading Dose: Inject 100mg SQ at Week 0 and Week 4. ☐ Maintenance Dose: Inject 80mg SQ once every 4 weeks (starting at Week 4).		
☐ Xeljanz®	☐ 5mg Tablet	☐ Take one tablet orally once daily. ☐ Take one tablet orally twice daily.		
☐ Xeljanz® XR	☐ 11mg Tablet	☐ Take one tablet orally once daily.		
☐ Yusimry®	☐ 40mg/0.8mL Pen	☐ Inject 40mg SQ every week. ☐ Inject 40mg SQ every other week.		
☐ Yuflyma®	☐ 40mg/0.4mL Pen ☐ 40mg/0.4 Syringe	☐ Inject 40mg SQ every week. ☐ Inject 40mg SQ every other week.		

PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

By signing this form and using this pharmacy's services, you are authorizing this pharmacy to serve as your prior authorization designated agent in dealing with prescription and medical insurance companies.

☐ May Substitute/Product Selection Permitted/Substitution Permissible

Prescriber Signature _____ **Date** _____

☐ Dispense as Written/Brand Medically Necessary/Do Not Substitute/No Substitution/May Not Substitute

Prescriber Signature _____ **Date** _____

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "**No Substitution**" _____ **NY & Iowa** providers, please submit electronic prescription.