

Rheumatoid Arthritis Enrollment Form

Phone: 800-476-7496
Fax: 888-985-9223



SINCE 1933
BOOTHWYN PHARMACY

PATIENT INFORMATION (PLEASE PRINT)					
Patient Name (Last, First, Mi)					<input type="checkbox"/> Male <input type="checkbox"/> Female
Date of Birth (mm/dd/yyyy)	SS#	Phone (Daytime)		Phone (Evening)	
Street Address (Please include Suite/Apt Number)			City	State	Zip
INSURANCE INFORMATION (PLEASE ATTACH COPY OF PATIENT'S PHARMACY BENEFIT CARD - FRONT AND BACK)					
Primary Insurance	Policy #	Group #	Policy Holder	Phone	
DIAGNOSIS / MEDICAL INFORMATION (Please indicate primary and secondary diagnosis)					
<input type="checkbox"/> 714.0 Rheumatoid Arthritis	<input type="checkbox"/> 696.0 Psoriasis Arthritis	<input type="checkbox"/> Other ICD9 _____		Is patient new to therapy? <input type="checkbox"/> yes <input type="checkbox"/> no Date of Dx: __/__/__	
Patient tested for TB: <input type="checkbox"/> yes <input type="checkbox"/> no		If yes, Date __/__/____		Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative	
Patient Weight: _____			Drug Allergies: _____ OR <input type="checkbox"/> NKDA		
PREVIOUS MEDICATIONS (Please specify dosage and time on therapy)					
<u>Medication Strength and Dose</u>		<u>Date of Therapy</u>		<u>Reason for Discontinuing</u>	
PRESCRIPTION INFORMATION					
<u>Medication</u>	<u>Dose / Strength</u>		<u>Directions</u>	<u>Quantity</u>	<u>Refills</u>
<input type="checkbox"/> Actemra® (tocilizumab)	<input type="checkbox"/> 80mg/4ml <input type="checkbox"/> 200mg/10ml <input type="checkbox"/> 400mg/20ml	_____ mg/ kg	<input type="checkbox"/> Induction Dose: 4mg/kg every 4 weeks <input type="checkbox"/> Maintenance Dose: 8mg/kg every 4 weeks <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Cimzia® (certolizumab-pegol)	<input type="checkbox"/> Cimzia® Starter Kit 6 - 200mg prefilled syringes <input type="checkbox"/> 200 mg prefilled syringes <input type="checkbox"/> 200 mg vials		<input type="checkbox"/> Induction Dose: Two(#2) 200 mg prefilled syringes day SC (400mg); and Two (#2) 200 mg prefilled syringes SC (400mg) at end of week 2; and Two (#2) 200 mg prefilled syringes SC (400mg) at end of week 4 <input type="checkbox"/> Maintenance Dose: 200mg SC every OTHER week (every 2 weeks) <input type="checkbox"/> Maintenance Dose: 400mg SC every 4 weeks – inject #2 syringes <input type="checkbox"/> Other: _____	1 kit	0
<input type="checkbox"/> Enbrel® (etanercept)	<input type="checkbox"/> 50 mg/ml pre-filled syringe <input type="checkbox"/> 50 mg/ml SureClick™ Auto Syringe <input type="checkbox"/> 25 mg/0.5ml pre-filled syringe <input type="checkbox"/> 25 mg vial		<input type="checkbox"/> 50mg SC once a week <input type="checkbox"/> 25mg SC twice a week (3-4 days apart) <input type="checkbox"/> 25mg SC twice a week		
<input type="checkbox"/> Humira® (adalimumab)	<input type="checkbox"/> 40mg Pen Auto Syringe <input type="checkbox"/> 40mg prefilled syringe <input type="checkbox"/> 20mg prefilled syringe		<input type="checkbox"/> 40mg SC every OTHER week <input type="checkbox"/> 20mg SC every OTHER week <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Kineret® (anakinra)	<input type="checkbox"/> 100mg prefilled syringe		<input type="checkbox"/> 100mg (1 syringe) SC once a day		
<input type="checkbox"/> Orencia® (abatecept)	<input type="checkbox"/> 250mg vial	Not for self-administration	<input type="checkbox"/> Infuse _____mg in 100ml 0.9% NaCl at weeks 0,2 and 4; then every 4 weeks <input type="checkbox"/> 125mg SC once weekly		
<input type="checkbox"/> Remicade® (infliximab)	<input type="checkbox"/> 100mg vials # of vials _____ Not for self-administration		<input type="checkbox"/> Infuse 3mg/kg in 250ml 0.9% NaCl as directed <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Rituxan® (rituximab)	<input type="checkbox"/> 100mg/10ml vial <input type="checkbox"/> 500mg/50ml vial	Not for self-administration	<input type="checkbox"/> _____		
<input type="checkbox"/> Simponi™ (golimumab)	<input type="checkbox"/> 50mg/0.5ml pre-filled syringe <input type="checkbox"/> 50mg/0.5ml SmartJect™		<input type="checkbox"/> 50mg SQ Once Monthly <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Xeljanz™ (tofacitinib)	<input type="checkbox"/> 5mg tablet		<input type="checkbox"/> Take one 5mg by mouth twice daily <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Other					
DELIVERY AND PATIENT EDUCATION INSTRUCTIONS					
<input type="checkbox"/> Patient's Home	<input type="checkbox"/> Physician's Office	Date Needed: __/__/____		Patient needs Teaching/Education Kit? <input type="checkbox"/> yes <input type="checkbox"/> no	
PHYSICIAN CONTACT INFORMATION AND AUTHORIZATION					
Physician Name		License #	DEA #	UPIN #	
Office Contact		Phone	Fax	NPI#	
Street Address (Please include Suite Number)			City/State/Zip		
Physician's Signature (required)			Date (required)		
This prescription will be filled generically unless Prescriber writes "DAW" in the box to the right. <div style="border: 1px solid black; width: 100px; height: 20px; display: inline-block; margin-left: 100px;"></div>					