FAX REFERRAL TO: 1-888-801-0404
PHONE: 1-888-570-9077

RHEUMATOLOGY ENROLLMENT FORM

Date: ___________________ • Ship to: ☐ Patient ☐ Office

Needs by Date: ___________________

PATIENT INFORMATION

(Complete the following *or send patient demographic sheet*)

Name: ______________________________

Address ______________________________

City, State, Zip: ______________________________

Cell Phone: ______________________________

Home Phone: ______________________________

SS#: ______________________________

Date of Birth: ______________________________

PRESCRIBER INFORMATION

Prescriber Name: ______________________________

DEA #: ______________ NPI #: ______________

Group/Hospital: ______________________________

Address: ______________________________

City, State, Zip: ______________________________

Phone: ______________ Fax: ______________

Contact Person: ______________________________

INSURANCE INFORMATION

Primary Insurance/Prescription Card:
PLEASE FAX COPY OF INS CARD (front and back if available)
Secondary Insurance/Prescription Card:
PLEASE FAX COPY OF INS CARD (front and back if available)

DIAGNOSIS / ICD 10 CODE

☐ ______________	☐ ______________
☐ ______________	☐ ______________
☐ ______________	☐ ______________
☐ ______________	☐ ______________

PRIOR FAILED MEDICATIONS/CONCOMMITANT DISEASES

(PLEASE LIST)

☐	☐
☐	☐

☐ Patient has had negative TB test

Workers Comp Information

Case # Carrier:

Employer:

Name of Adjuster: Ph#

Date of accident:

PRESCRIPTION INFORMATION

MEDICATION		FREQUENCY/DIRECTIONS FOR USE	QUANTITY	REFILL
☐ ENBREL®	☐ 50 mg Syringe ☐ 50 mg Sure-click	☐ 50 mg once a week ☐ 50 mg twice a week	☐ 28 day supply ☐ 84 day supply	
☐ HUMIRA®	☐ 40 mg Syringe ☐ 40 mg Pen ☐ 20 mg Syringe	☐ 40 mg every other week ☐ 20 mg every other week ☐ Other:	☐ 28 day supply ☐ 84 day supply	
☐ ORENCIA®	☐ 125 mg Syringes ☐ 250 mg vials	☐ 125 mg once a week ☐ Induction dose: Infuse _______mg day 1, week 2, and week 4 ☐ Maintenance Dose: Infuse _______mg every 4 weeks	☐ 28 day supply ☐ 84 day supply	
☐ ACTEMRA®	☐ 162 mg pfs ☐ ____mg vials	☐ Patients < 100kg dose 162 mg sc every other week ☐ Patients > 100kg dose 162 mg sc once per week ☐ Induction dose ________(4mg/kg) every 4 weeks ☐ Maintenance dose _______ (8mg/kg) every 4 weeks	☐ 28 day supply ☐ 84 day supply	
☐ OTEZLA®	☐ 30 mg Tablet ☐ Titration Starter pack	☐ Maintenance dose: 30 mg tablet twice daily ☐ Titration Starter pack: As Directed	☐ 30 day supply ☐ 90 day supply	
☐ XELJANZ®	☐ 5 mg tablets	☐ Take one tablet twice daily	☐ 28 day supply ☐ 84 day supply	
☐ SIMPONI®	☐ 50 mg Smartject ☐ 50 mg PFS	☐ Inject 50 mg subcutaneously once per month ☐ Other:______________________	☐ 28 day supply ☐ 84 day supply	
	☐ARIA 50 mg/4 ml vial	☐ 2 mg/kg IV infusion over 30 minutes at weeks 0, 4, then every 8 weeks		
☐ REMICADE®	☐ 100 mg vials	☐ Induction Dose: IV at 5 mg/kg (Dose= _____mg) at 0, 2, and 6 weeks. ☐ Maintenance Dose: IV at 5 mg/kg (Dose= _____mg) every 8 weeks. ☐ Other: ______________________________	☐ 28 day supply ☐ 84 day supply	
☐ RITUXAN®	☐ 100 mg vials ☐ 500 mg vials	☐ Infuse 1000 mg week 0, and 2 ☐ Other:______________________________	☐ 2 doses ☐Other______	
☐ RECLAST®	☐ 5 mg / 100ml vial	☐ Infuse 5 mg once per year	☐ One	
☐ IVIG	☐ 10% solution	☐ Dose:______________________ ☐ Patient requires home infusion services	☐	
☐ Other:				

____
Prescriber Signature and Date

☒ *I authorize Focus Rx staff or its representatives to act as an agent of prescriber to execute any prior authorization or appeal on my behalf.*

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