WELLPARTNER PHARMACY | RHEUMATOLOGY ENROLLMENT FORM

wellpartner

FAX FORM TO: 1.877.597.3070 | **PHONE:** 1.800.473.3516 | **EMAIL:** specialty@wellpartner.com

*Complete the following **or include demographic sheet**.*

1. PATIENT INFORMATION

Name:

Address:

City, State, ZIP:

Primary Phone: - - DOB: / /

Alternate Phone: - - Gender:

Email:

Primary Language: Last Four of SSN:

2. PRESCRIBER INFORMATION

Name:

DEA #: NPI #: State Lic. #:

Group or Hospital:

Address:

City, State, Zip:

Phone: - - Fax: - -

Contact Person: Phone: - -

3. INSURANCE INFORMATION

*Fax copy of **prescription** and **insurance cards** with this form, if available (front and back)*

Primary Insurance Company Name:

Primary Cardholder Name:

Relationship: ◯ Self ◯ Spouse/Partner ◯ Child/Dependent

Phone: - - Member ID: Group #:

Secondary Insurance Company Name:

Secondary Cardholder Name:

Relationship: ◯ Self ◯ Spouse/Partner ◯ Child/Dependent

Phone: - - Member ID: Group #:

4. DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: / /

◯ MØ6.9 Rheumatoid arthritis, unspecified
◯ MØ8.9 Juvenile arthritis, unspecified
◯ M45.9 Ankylosing spondylitis
◯ L4Ø.5 Arthropathic psoriasis
◯ Other:

Prior (failed medications)

Medication	Duration of Tx/Reason for d/c

Has patient received injection training? ◯ Yes ◯ No

Ship to: ◯ Patient ◯ Office ◯ Other:

Height (in/cm): Weight (lb/kg): ESR & date: / / CRP & date: / /

Has patient had TB test? ◯ Yes ◯ No If yes, results:

Has patient tried and failed 8-12 weeks of oral systemic DMARD agent? ◯ Yes ◯ No

Are there any contraindications to any arthritis agents? ◯ Yes ◯ No
If yes, drug(s): Reason(s):

Please check if patient has any of the following: ◯ Liver failure ◯ Lymphoma ◯ Serious/active infection

Is patient at risk for hepatitis B infection? ◯ Yes ◯ No
If yes, has hepatitis B been ruled out or treatment initiated? ◯ Yes ◯ No

Concomitant Medications: ◯ Methotrexate ◯ Other:

Allergies:

5. PRESCRIPTION INFORMATION

Medication	Dose/Strength	Directions	Quantity	Refills
◯ Actemra™	◯ 162 mg/0.9 ml prefilled syringe	◯ Patients < 100 kg: Inject 162 mg SQ every other week, followed by an increase to every week based on clinical response ◯ Patients ≥ 100 kg: Inject 162 mg SQ every week		
◯ Cimzia™	◯ Starter kit	◯ Inject 400 mg SQ on day 1, at week 2, and at week 4	1 kit (6 vials)	0
	◯ 200 mg/1 ml prefilled syringe ◯ 200 mg vial	◯ Inject 200 mg SQ every other week ◯ Inject 400 mg SQ every 4 weeks ◯ Other:		
◯ Enbrel™	◯ 25 mg/0.5 ml PFS ◯ 25 mg vial ◯ 50 mg/ml prefilled syringe (PFS) ◯ 50 mg/ml Sureclick Autoinjector	◯ Inject 50 mg SQ once a week ◯ Inject 25 mg SQ twice a week (72-96 hours apart) ◯ Other:		
◯ Humira™	◯ Pen ◯ 20 mg/0.4 ml ◯ Prefilled syringe ◯ 40 mg/0.8 ml	◯ Inject 20 mg SQ every other week ◯ Inject 40 mg SQ every other week ◯ Other:		
◯ Kineret™	◯ 100 mg prefilled syringe	◯ Inject 100 mg (one syringe) SQ once a day		
◯ Orencia	◯ 250 mg vial ◯ 125 mg subcutaneous	◯ Infuse _____ mg in 100ml 0.9% NaCl at weeks 0, 2, and 4, then every 4 weeks ◯ Other:		
◯ Remicade™	◯ 100 mg vial ◯ _____ mg/kg	◯ IV in 250ml 0.9% NaCl at 0, 2, and 6 weeks. ◯ IV in 250ml 0.9% NaCl at every _____ weeks		
◯ Rituxan™	◯ 100 mg/10 ml vial ◯ 500 mg/50 ml vial	◯ Infuse two doses of 1000mg in 1 liter 0.9% NaCl two weeks apart. ◯ Other:		
◯ Simponi™	◯ 50 mg/0.5 ml SmartJect Autoinjector ◯ 50 mg/0.5 ml prefilled syringe	◯ Inject 50 mg (0.5 ml) SQ once a month ◯ Other:		
◯ Simponi™ ARIA	◯ 50 mg/4 ml (12.5 mg/ml) in a single use vial			
◯ Stelara™	◯ 45 mg/0.5 ml in a single-use PFS ◯ 90 mg/ml in a single-use prefilled syringe (PFS)	◯ Inject 45 mg SQ initially and 4 weeks later, then 45 mg SQ every 12 weeks ◯ For patients > 100 kg with co-existent moderate to severe plaque psoriasis, 90 mg initially and 4 weeks later, followed by 90 mg every 12 weeks		
◯				

Ancillary supplies and kits will be provided as needed for administration.

6. PRESCRIBER SIGNATURE

X / /

DISPENSE AS WRITTEN DATE

X / /

PRODUCT SUBSTITUTION PERMITTED DATE

IMPORTANT NOTICE: This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address or telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee.