elixir
SPECIALTY PHARMACY

Rheumatology Adult Enrollment Form

Phone: 877-437-9012 Fax: 877-309-0687

☐ New to Therapy
☐ Current Therapy

Patient Information

Patient Name: ______________________________
Date of Birth: __________ Gender: _________ Last for of SSN: __________
Address: ______________________________
City: ____________________State:________Zip:________________
Home Phone: _________________ Work Phone: _________________
Cell Phone: _______________ E-mail:_______________________
Patient Weight: ___________kg/lbs Patient Height: ____________in/cm
Please attach copy of front and back of patient's prescription ins. card(s) if applicable
Insurance Company Name: ______________________________
Insurance Company Phone: ______________________________
Policy holder:______________________________
Policy holder Employer:______________________________
Relationship to Patient:______________________________
ID# ________________________Group#______________________
RxBIN: _____________________RxPCN:______________________

Prescriber Information

Practice/ Organization Name: ______________________________
Physician Name: ______________________________
Contact Person: _________________________ Contact's Phone: ____________________
Address:______________________________ ____________________
City: ______________________________ State: _________________ Zip: __________
Office Phone#:__________________________ Office Fax#:_____________________
DEA#______________________________ NPI#______________________________
License#:________________________ Medicaid UPIN#:__________________________
Physician Specialty: ______________________________
Date Shipment Needed: ______________________________
Ship to: ☐Patient ☐Prescriber ☐Other______________________________
Shipment Address: ______________________________ Attn: ____________________
City: ________________________State: ______________Zip:___________

If shipped to the physician's office, physician accepts on behalf of patient for administration in office.

Diagnosis and Clinical Information

Diagnosis (ICD-10): ☐ M06.9 Rheumatoid Arthritis ☐ M45.9 Ankylosing Spondylitis ☐ L40.59 Psoriatic Arthritis ☐ M08.01 Juvenile chronic polyarthritis
☐ Other:______________________________
Date of Diagnosis or Years with Disease:______________________________
Patients Allergies: ______________________________ Latex allergy: ☐Yes ☐No
Has the patient had a NEGATIVE tuberculin test? ☐Yes ☐No If yes, date of test:____________
Is the patient a carrier of Hepatitis B virus? ☐Yes ☐No If yes, has a physician initiated treatment?: ______________________________
Previous failed therapies, discontinuation reasons and dates:

Therapy	Discontinuation Reason	Dates

Is patient on Methotrexate: ☐ Yes ☐ No
Comorbidities: ______________________________

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Prescriber Name: ______________________ **Phone:** ______________ **Date:** ______________

Prescriber Address: ____

Medication	Strength	Directions	Quantity/Refills
☐ **Actemra®** ☐ Pen ☐ PFS	162mg	☐ Inject 162mg SQ every other week (weight < 100kg) ☐ Inject 162mg SQ once every week (weight >100kg)	Quantity: Refills:
☐ **Cimzia®** ☐ Vial ☐ PFS	☐ Starter kit (200mg PFS) ☐ 200mg	☐ Initial titration: Inject 400mg SQ at weeks 0,2, and 4 ☐ Inject 400mg SQ every 4 weeks ☐ Inject 200mg SQ every 2 weeks ☐ Other:	Quantity: Refills (maint only):
☐ **Cosentyx®** ☐ Pen ☐ PFS	150mg	☐ Initial titration: Inject 150mg SQ at weeks 0,1,2, and 3 ☐ Initial titration: Inject 300mg SQ at weeks 0,1,2, and 3 ☐ Inject 150mg SQ at week 4 and then every 4 weeks ☐ Inject 300mg SQ at week 4 and then every 4 weeks	Quantity: Refills (maint only):
☐ **Enbrel®** ☐ Pen ☐ PFS ☐ Mini Cartridge ☐ Vial	☐ 50mg ☐ 25mg	☐ Inject 50mg SQ once weekly ☐ Inject 50mg SQ twice weekly ☐ Inject 25mg SQ once weekly ☐ Inject 25mg SQ twice weekly ☐ Other:	Quantity: Refills:
☐ **Humira®** ☐ Pen ☐ PFS	☐ 40mg/0.4mL ☐ 40mg/0.8mL ☐ 80mg/0.8mL	☐ Inject 40mg SQ every other week ☐ Inject 40mg SQ once every week ☐ Inject 80mg SQ every other week ☐ Other:	Quantity: Refills:
☐ **Kevzara®** ☐ Pen ☐ PFS	☐ 150mg ☐ 200mg	☐ Inject 150mg SQ every two weeks ☐ Inject 200mg SQ every two weeks	Quantity: Refills:
☐ **Olumiant®**	☐ 1mg ☐ 2mg ☐ 4mg	☐ Take 1 tablet PO once daily	Quantity: Refills:

Prescriber Signature: *X*______________________ **Date:** ______________________

If Brand required "Dispense as Written" must be handwritten

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Prescriber Name: ____________________ **Phone:** ____________________ **Date:** ____________________

Prescriber Address: ____

Medication	Strength	Directions	Quantity/Refills
☐ **Orencia®** ☐ Pen ☐ PFS	125mg	☐ Inject 125mg SQ once weekly	Quantity: Refills:
☐ **Otezla®**	☐ Starter pack ☐ 30mg tab	☐ Initial titration: • Day 1: 10mg PO QAM; Day 2: 10mg PO QAM & 10mg PO QPM; Day 3: 10mg PO QAM & 20mg PO QPM; Day 4: 20mg PO BID; Day 5: 20mg PO QAM & 30mg PO QPM; Day 6 & after: 30mg PO BID ☐ Take 30mg PO twice daily	Quantity: Refills (maint only):
☐ **Rinvoq®**	☐ ER 15mg ☐ Other:	☐ Take 1 tablet (15mg) PO once daily ☐ Other:	Quantity: Refills:
☐ **Simponi®** ☐ Pen ☐ PFS	☐ 50mg ☐ Other:	☐ Inject 50mg SQ once per month ☐ Other:	Quantity: Refills:
☐ **Skyrizi®** ☐ Pen ☐ PFS	150mg	☐ Initial titration: Inject 150mg SQ at week 0 ☐ Inject 150mg SQ at week 4 and then every 12 weeks thereafter	Quantity: Refills (maint only):
☐ **Stelara®**	☐ 45mg PFS ☐ 90mg PFS	☐ Initial titration: Inject at week 0 ☐ Inject at week 4 and then every 12 weeks thereafter	Quantity: Refills (maint only):
☐ **Taltz®** ☐ Pen ☐ PFS	80mg	☐ Initial titration: Inject 160mg at week 0 ☐ Inject 80mg every 4 weeks	Quantity: Refills (maint only):
☐ **Tremfya®** ☐ Pen ☐ PFS	100mg	☐ Initial titration: Inject 100mg at week 0 ☐ Inject 100mg at week 4 and then every 8 weeks thereafter	Quantity: Refills (maint only):
☐ **Xeljanz®**	☐ XR 11mg ☐ 5mg	☐ Take 5mg PO twice daily ☐ Take 11mg XR PO once daily	Quantity: Refills:
☐ **Other:**		☐ Other:	Quantity: Refills

Prescriber Signature: *X*____________________ **Date:** ____________________

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