elixir
SPECIALTY PHARMACY

Rheumatology Infusion 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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Patient Name: ______________________ **Patient Date of Birth:** ______________

Prescriber Name: ______________________ **Phone:** ____________ **Date:** ____________

Prescriber Address: ____

Medication	Strength	Directions	Quantity/Refills
☐ **Actemra®**	20mg/mL vial	☐ Infuse_________mg/kg IV every 4 weeks as directed ☐ Other:	Quantity: Refills:
☐ **Orencia®**	☐ 500mg (wt < 60kg) ☐ 750mg (wt 60-100kg) ☐ 1000mg (wt>100kg) ☐ 10mg/kg (wt<75kg for JA)	☐ Initial titration: Infuse over 30 mins via IV every 2 weeks for 3 doses ☐ Infuse over 30 mins every 4 weeks ☐ Other:	Quantity: Refills (maint only):
☐ **Remicade®** ☐ **Infectra®** ☐ **Renflexis®**	☐ 3mg/kg ☐ 5mg/kg ☐ 10mg/kg ☐Other:	☐ Initial titration: Infuse over 2 hours at week 0, week 2, and week 6 ☐ Infuse over 2 hours every 6 weeks ☐ Infuse over 2 hours every 8 weeks ☐ Other:	Quantity: Refills:
☐ **Rixuan®** ☐ **Truxima®** ☐ **Ruxience®**	☐ 100mg/10mL ☐ 500mg/50mL	☐ Infuse 1000mg via IV bolus on Day 1 and Day 15 every 6 months ☐ Other:	Quantity: Refills:
☐ **Simponi Aria®**	50mg/4mL vial	☐ Infuse 2mg/kg via IV over 30 mins at Week 0 ☐ Infuse 2mg/kg via IV over 30 mins at Week 4 ☐ Infuse 2mg/kg via IV over 30 mins every 8 weeks	Quantity: Refills (maint only):
☐ **Other**		☐ Other:	Quantity: Refills:
☐ **Other**		☐ Other:	Quantity: Refills:

Prescriber Signature: *X*________________________ **Date:** ________________

If Brand required "Dispense as Written" must be handwritten

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