elixir SPECIALTY PHARMACY

Rheumatology Pediatric 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®** ☐ Pen ☐ PFS	162mg	☐ Inject 162mg SQ once every week ☐ Inject 162mg SQ once every other week ☐ Inject 162mg SQ every three weeks	Quantity: Refills:
☐ **Enbrel®** ☐ Pen ☐ PFS ☐ Mini Cartridge ☐ Vial	☐ 50mg ☐ 25mg	☐ Inject 50mg SQ once every week ☐ Inject 25mg SQ once every week ☐ Inject ______mg SQ once every week ☐ Other:	Quantity: Refills:
☐ **Humira®** ☐ Pen ☐ PFS	☐ 10mg/0.1ml PFS only ☐ 20mg/0.2ml PFS only ☐ 40mg/0.4mL ☐ 40mg/0.8mL	☐ Inject 10mg SQ every other week ☐ Inject 20mg SQ every other week ☐ Inject 40mg SQ every other week ☐ Inject 40mg SQ once every week ☐ Other:	Quantity: Refills:
☐ **Orencia®** ☐ Pen ☐ PFS	☐ 50mg/0.4ml ☐ 87.5mg/0.7ml ☐ 125mg	☐ Inject 50mg SQ once a week ☐ Inject 87.5mg SQ once a week ☐ Inject 125mg SQ once a week ☐ Other:	Quantity: Refills:
☐ **Xeljanz®**	☐ 1mg/ml solution ☐ 5mg tablet	☐ Take 3.2mg PO twice daily ☐ Take 4mg PO twice daily ☐ Take 5mg PO twice daily ☐ Other:	Quantity: Refills:
☐ **Other**		☐ Other:	Quantity: Refills

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

If Brand required “Dispense as Written” must be handwritten

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