elixir
SPECIALTY PHARMACY

Rheumatology Enrollment Form

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

☐ **New to Therapy**
☐ **Current Therapy**

Customer Information

Customer Name: _____

Date of Birth: _____ Gender: Male or Female

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-mail: _____

Please attach copy of front and back of customer's insurance card(s)

Insurance Company Name: _____

Insurance Company Phone: _____

Policy holder: _____

Policy holder Employer: _____

Relationship to Customer: _____

ID# _____ Group# _____

RxBIN: _____ RxPCN: _____

Prescriber Information

Practice/ Organization Name: _____

Physician Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone#: _____ Fax#: _____

DEA# _____ NPI# _____

License#: _____ Medicaid UPIN#: _____

Physician Specialty: _____

Date Shipment Needed: _____

Ship to: ☐Patient ☐Prescriber ☐Infusion Clinic

Shipment Address: _____

Attn: _____

City: _____ State: _____ Zip: _____

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

Privacy & Confidentiality of Information Notice: This communication may contain non-public, confidential, or legally privileged information intended for the sole use of the designated recipient(s). If you are not the intended recipient, or have received this communication in error, please notify the sender immediately by reply email or by telephone at the number stated above and delete all copies of this communication, including any attachments, without reading them or saving them to disk. If you are the intended recipient, you must secure the contents of this communication in accordance with all applicable state or federal requirements related to the privacy and confidentiality of information, including the HIPAA Privacy guidelines.

Clinical Information and Prescription

Diagnosis and Clinical Information:

☐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: _____

Patient Weight: _____ kg / lbs Patient Height: _____ cm / in

Has the patient had a NEGATIVE tuberculin skin test? ☐ Yes ☐ No

Is the patient a carrier of the Hepatitis B virus? ☐ Yes ☐ No Latex allergy: ☐ Yes ☐ No

Prior DMARD's and length of treatment: _____

Expected First Dose Date: Injection training needed: ☐ Yes ☐ No

☐ **Actemra®** (tocilizumab) ☐ 162 mg SC syrinige ☐ 162 mg SC ACTPen ☐ 20mgml IV vial (patient weight needed)
Inject 162 mg SC ☐ once weekly (>/= 100 kg) OR ☐ every other week (<100 kg) Infuse _____ mg/kg IV every 4 weeks as directed

☐ **Cimzia®** (certolizumab pegol)
Initial Dose: ☐400mg SC @ 0, 2, 4 weeks prefilled syringe OR ☐400mg SC @ 0, 2, 4 weeks lyophilized powder vial (in office)
Maintenance Dose: ☐ 400mg SC every 4 weeks ☐200mg SC every 2 weeks ☐Prefilled Syringe ☐Vial

☐ **Enbrel®** (etanercept) Dose: ☐ 50mg SureClick ☐ 50mg Prefilled Syringe ☐ 25mg Prefilled Syringe ☐ 25mg Vial
Dispense: ☐ Inject SC once per week ☐Inject SC twice per week ☐ (JIA) inject 0.8mg/kg, max 50mg/week

☐ **Humira®** (adalimumab) Dose: ☐40mg Pen Auto Injector ☐40mg Prefilled Syringe ☐ Citrate/buffer free formulation
☐ 20 mg Prefilled Syringe ☐10mg Prefilled Syringe
Dispense: ☐ Inject SC once every other week ☐ Inject SC once per week ☐Other:

☐ **Kevzara®** (sarilumab) Inject SC once every 2 weeks ☐ Prefilled Syringe OR ☐ Prefilled Pen
Dose: ☐ 150mg/1.14ml ☐ 200mg/1.14ml

☐ **Olumiant®** (baricitinib) 2 mg PO once daily

☐ **Orencia®** (abatacept) ☐ Inject 125mg Prefilled Syringe SC once weekly
☐ Infuse IV over 30 minutes every 2 weeks for 3 doses. Starting at week 8, infuse over 30 minutes every 4 weeks
☐500mg (pat. <60kg) ☐750mg (60-100kg) ☐1000mg (>100kg) ☐10mg/kg if less than 75kg (JA)

☐ **Remicade®** (infliximab) OR ☐**Inflectra®** OR ☐**Renflexis®** Infuse IV over 2 hours as directed
Dose: ☐3mg/kg @ 0, 2, 6 weeks ☐3mg/kg every 8 weeks ☐5mg/kg @ 0, 2, 6 weeks then every 6 weeks thereafter (Ankyl Spon.)
☐10mg/kg @ 0, 2, 6 weeks then every 6 weeks thereafter ☐Other dosing: _____

☐ **Rinvoq®** (upadacitinib) 15 mg PO once daily

☐ **Rituxan®** (rituximab) Infuse 1000mg IV bolus on day 1 and 15 every 6 months.

☐ **Simponi®** (golimumab) Inject SC once per month
☐ 50mg SmartJect™ OR ☐ 50mg prefilled syringe

☐ **Simponi Aria®** (golimumab)
Infuse 2 mg/kg IV over 30 minutes; repeat dose at week 4 and then every 8 weeks thereafter

☐ **Xeljanz®** (tofacitinb) 5 mg PO twice daily

☐ **Xeljanz XR®** (tofacitinib) 11 mg PO once daily

Quantity Prescribed: ☐QS 30 days ☐Other: ____ Refills Authorized: ☐ 0 ☐1 ☐2 ☐3 ☐ 6 ☐1 yr ☐Other: ____

Physician Signature (no stamps): _____ Date: _____