# Rheumatology Enrollment Form

**Phone:** (706) 849-4161 **Fax:** (706) 798-9683

| **PATIENT INFORMATION** (Complete or include demographic sheet) | **PRESCRIBER INFORMATION** |
|---|---|
| Patient Name:_____ DOB:_____ | Prescriber Name: _____ |
| Address: _____ | State License #: _____ NPI#: _____ |
| City, State, Zip:_____ | DEA#: _____ |
| Primary Phone:_____ | Organization:_____ |
| Alternate Phone:_____ Gender:_____ | Address:_____ |
| Email:_____ | City, State, Zip: _____ |
| SSN:_____ | Phone: _____ Fax: _____ |
| Allergies:_____ | Contact Person: _____ Tax ID: _____ |

**INSURANCE INFORMATION**: Please fax/scan the front and back of the insurance card

**DIAGNOSIS AND CLINICAL INFORMATION** (Please fax recent clinical notes, labs, tests supporting information to expedite prior authorization process)

Diagnosis (ICD10) : _____ Date of Diagnosis: _____

Is Patient currently on RA therapy: □ Yes □ No If Yes, Medications: _____

Prior failed medications *(dates of therapy and reason for discontinuation*): _____

_____

TB/PPD: □ Yes □ No Tb Test Date:_____ Has Hepatitis B been ruled out or treatment been initiated: □ Yes □ No

Does patient have a latex allergy? : □ Yes □ No

Is Patient at risk for osteoporotic fracture? : □ Yes □ No

BMD/T-Score_____ Date _____

□ Attached active medication list for pharmacist review

**Delivery Options**: □ Patient home □ Office □ Other (specify): _____

**Injection Training:** Expected date: _____ □ MD office □ Barney's Specialty □ Alternate program

| MEDICATION | DOSE/STRENGTH | SIG | QTY | REF |
|---|---|---|---|---|
| □ **Actrema** | □ 162mg/0.9ml Prefilled Syringe | □ Inject 1 syringe SC every week<br>□ Inject 1 syringe SC every other week | | |
| □ **Enbrel** | □ 50mg/ml Prefilled Syringe<br>□ 50mg/ml SureClick Autoinjector<br>□ 25mg/0.5ml Prefilled Syringe | □ Induction Dose: Inject 50mg SC TWICE a week (72-96 hours apart for three months)<br>□ Maintenance Therapy: Inject 50mg SC once week | | |
| □ **Forteo** | □ 1 kit | □ Inject 20mcg SC ONCE Daily as directed | | |
| □ **Humira** | □ 20mg/0.4ml Prefilled Syringe<br>□ 40mg/0.8ml Pen<br>□ 40mg/0.8ml Prefilled Syringe<br>□ 40mg Kit (4x0.8ml)<br>□ 40mg Starter Kit (6x0.8ml) | □ Initial Dose: Inject 80mg SC on day 1 and day 15<br>□ Maintenance Dose: Inject 40mg SC every other week (starting 1 week after initial dose) | | |
| □ **Orencia** | □ 125mg/ml Prefilled Syringe | □ Inject 125mg SC ONCE weekly | | |
| □ **Otezla** | □ 30mg | □ Take one tablet twice daily | | |
| □ **Prolia** | □ 60MG Prefilled Syringe | □ Inject 60mg SC every six months | | |
| □ **Simponi** | □ 50mg/0.5ml Pre-filled Syringe<br>□ 50mg/0.5ml Autoinjector | □ Inject 50mg SC ONCE a month | | |
| □ **Stelara** | □ 45mg/0.5ml Syringe<br>□ 90mg/ml Syringe | □ Inject one syringe SC every 3 months | | |
| □ **Xeljanz** | □ 5mg | □ Take 5mg by mouth TWICE daily | | |
| □ | | | | |

**Patient Support Program:** Please sign and date below to enroll in the pharmaceutical company assisted patient support programs and patient funding.

PATIENT SIGNATURE _____ Date: _____

****By signing this form and utilizing our services, you are authorizing Barney's Specialty Pharmacy and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.****

X_____ X_____

Dispense as written/Date Substitution Permitted/ Date