# RHEUMATOLOGY ENROLLMENT FORM - "SPECIALTY"

## PATIENT INFORMATION

Last Name _____ First Name _____

Social Security # _____ Date of Birth _____

Address: _____

Sex □ M □ F Wgt:_____ Ht:_____ Phone:_____

Allergies:_____ Cell:_____

## TREATMENT ARRANGEMENTS

Start Date: _____

Ship Meds: □ Home □ Doctor's Office

Teaching by: □ Doctor's Office

□ Other: _____

## INSURANCE INFORMATION

**Insurance:** □ Medicare □ Medicaid □ Commercial: _____

ID _____ BIN_____ PCN _____ GROUP_____

**Diagnosis:** □ Rheumatoid Arthritis □ Ankylosing Spondylitis □ Osteoporosis □ Psoriatic Arthritis □ Lupus □ Gout □ Spondyloarthropathy □ Uveitis Date of Diagnosis: _____

**Prior Treatment:** □ **Humira** □ **Enbrel** □ **Stelara** □ **Others:**_____ **TB Test** □ **Positive** □ **Negative**

## PRESCRIPTION INFORMATION

| MEDICATION | STRENGTH | DOSAGE FORM | DIRECTIONS | QUANTITY | REFILLS |
|---|---|---|---|---|---|
| □ **Actemra** | □ 162mg<br>□ _____mg | INJECTION | □ Less than 100kg weight: Inject 162mg subq every other week, followed by an increase to every week based on clinical response.<br>□ Above 100kg weight: Inject 162mg subq every week.<br>□ Other: _____ | | |
| □ **Cimzia** | □ 200mg/1ml Prefilled Syringe<br>□ 200mg Vial | | □ Induction Dose: Inject 400mg subcutaneously on day 1, at week 2, and at week 4.<br>□ Maint. Dose: Inject 200mg subcutaneously every other week.<br>□ Maint. Dose: Inject 400mg subcutaneously every 4 weeks. | | |
| □ **Cosentyx** | □ 300mg □ Pen □ PFS<br>□ 150mg □ Pen □ PFS | | □ Initial Dose: Inject 300mg subq at weeks 0,1,2,3, and 4 weeks.<br>Each 300mg dose is given as 2 subq inj of 150mg.<br>□ Maint Dose: Inject 300mg subq once 4 weeks.<br>Each 300mg dose is given as 2 subq inj of 150mg. | | |
| □ **Enbrel** | □ SureClick® Pen<br>□ Mini™with Auto Touch<br>□ Prefilled Syringe □ 25mg □ 50mg<br>□ Vials 25mg | | □ Inject 50mg SQ every week<br>□ Inject 25mg SQ TWICE a week (72-96 hours apart).<br>□ Other: _____ | | |
| □ **Humira** | □ Uveitis Starter Kit<br>□ 40mg Pen □ 40mg Pre-Filled Syringe<br>□ 80mg Pen | | □ **Uveitis Initial Dose:** Inject 80mg Subq on day 1, 40mg on day 8 and 40mg day 22 then maintenance.<br>□ **Maintenance Dose:** Inject 40mg Subq every other week.<br>□ **Maintenance Dose:** Inject 40mg Subq weekly. | | |
| □ **Humira CF** *(Citrate-free)* | □ Uveitis Starter Kit<br>□ 40mg Pen □ 40mg Pre-Filled Syringe<br>□ 80mg Pen | | □ **Uveitis Initial Dose:** Inject 80mg Subq on day 1, 40mg on day 8 and 40mg day 22 then maintenance.<br>□ **Maintenance Dose:** Inject 40mg Subq every other week.<br>□ **Maintenance Dose:** Inject 40mg Subq weekly. | | |
| □ **Kevzara** | □ 200mg<br>□ 150mg | | □ Inject 200mg subcutaneously once every two weeks.<br>□ Other: _____ | | |
| □ **Otrexup** | □_____mg/ml | | □ Inject _____mg Subcutaneously Once a week. | | |
| □ **Rasuvo** | □_____mg/ml | | □ Inject _____mg Subcutaneously Once a week. | | |
| □ **Stelara** | □ 45mg Prefilled Syringe<br>□ 90mg Prefilled Syringe | | □ Inject 45mg SQ at weeks 0, 4 & then every 12 weeks.<br>□ Inject 90mg SQ at weeks 0, 4 & then every 12 weeks. | | |
| □ **Simponi** | □ 50mg/0.5ml Prefilled SmartJect Autoinjector<br>□ 50mg/0.5ml Prefilled Syringe | | □ Inject 50mg (0.5ml) subcutaneously once a month.<br>□ Other: _____ | | |
| □ **Forteo** | □ 600ug/2.4 ml Delivery Device | | □ Inject 20ug (0.08 ml) Subcutaneously Once daily. | | |
| □ **Prolia** | □ 60mg/ml | | □ Inject 60mg/ml Subcutaneously Once every 6 months.<br>□ Other: _____ | | |
| □ **Tymlos** | □ 3120mcg/1.56ml | | □ Inject 80mcg Subq once daily. | | |
| □ **Taltz** | □ 80mg/ml Autoinjector<br>□ 80mg/ml Prefilled Syringe | | □ Inject 160mg Subcutaneously (two 80mg injections) at week 0, followed by 80mg every 4 weeks.<br>□ Other: _____ | | |
| □ **Otezla** | □ Starter Pack<br>□ 30mg Tablet | ORAL | □ Titrate: Take 1 tablet on day 1then twice daily as directed **OR date provided** _____.<br>□ Maintenance: Take 1 tablet by mouth twice daily.<br>□ Bridge RX: Take 1 tablet by mouth twice daily; disp. by OSP. | | |
| □ **Olumiant** | □ 2mg | | □ Take 2mg PO Once daily. | | |
| □ **Xeljanz** | □ 5mg | | □ Take 5mg PO Twice a day. | | |
| □ **Xeljanz XR** | □ 11mg | | □ Take 11mg PO Once daily. | | |

**Physician Signature:** _____ □ **DAW (Dispense as Written)** **Date:** _____

**Physician Name:** _____ **Phone:** _____ **Fax:** _____ **Office Contact:** _____

**Physician Address:** _____ **NPI:** _____ **DEA:**_____



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# RHEUMATOLOGY ENROLLMENT FORM - "INFUSION"

## PATIENT INFORMATION

Last Name _____ First Name _____

Social Security # _____ Date of Birth _____

Address: _____

Sex □ M □ F Wgt:_____ Ht:_____ Phone:_____

Allergies:_____Cell:_____

## TREATMENT ARRANGEMENTS

Start Date: _____

Ship Meds: □ Home □ Doctor's Office

Teaching by: □ Doctor's Office

□ Other: _____

**Diagnosis:** □ Rheumatoid Arthritis □ Ankylosing Spondylitis □ Osteoporosis □ Psoriatic Arthritis □ Lupus □ Gout □ Spondyloarthropathy

Date of Diagnosis: _____

## INSURANCE INFORMATION

**Insurance:** □ Medicare □ Medicaid □ Commercial: _____

ID _____ BIN_____ PCN _____ GROUP_____

**Premeds: □Tylenol 500mg 2 PO □ Loratidine 10mg PO □ Zyrtec 10mg PO □ Benadryl _____mg IV/PO (circle one)**
**□ SoluCortef _____mg IV □ Ondansetron___mg IV □ Promethazine__ mg IV □ Other _____**

√ Standing Order: Anaphylaxis Protocol √ **Skilled Nurse to start PIV, infuse per protocol, DC PIV each visit**

□ Lab Draw As Follows:_____

□ Quantiferon Gold Lab Draw Q _____ □ Patient to FU w/MD Q_____

**Prior Treatment: □ Humira □ Enbrel □ Stelara □ Others:_____ TB Test □ Positive □ Negative**

## PRESCRIPTION INFORMATION

| MEDICATION | STRENGTH | DOSAGE FORM | DIRECTIONS | QUANTITY | REFILLS |
|---|---|---|---|---|---|
| □ **Actemra** | □ 80mg/4ml<br>□ 200mg/10ml<br>□ 400mg/20ml<br>□_____mg/kg | IV | □ Induction Dose: 4 mg/kg every 4 weeks.<br>□ Maint. Dose: (based on clinical response): 8 mg/kg every 4 weeks.<br>□ Other: _____ | | |
| □ **Benlysta** | □ 10mg/kg | | □ Induction Dose: Administer 10 mg/kg on week 0, week 2 week 4.<br>□ Maint. Dose: 10 mg/kg once every 4 weeks after Induction dose.<br>□ Other: _____ | | |
| □ **Boniva** | □ 3mg/3ml Injection | | □ Inject 3mg/ml Once every 3 months.<br>□ Other: _____ | | |
| □ **Krystexxa** | □ 8mg/ml | | □ Inject 8mg/ml Intravenous once every 2 weeks.<br>□ Other: _____ | | |
| □ **Orencia** | □ 250mg Vial<br>□ _____ mg/kg | | □ Infuse _____mg in 100ml of 0.9% NaCl at weeks 0, 2, and 4, then every 4 weeks thereafter.<br>□ Other: _____ | | |
| □ **Remicade** | □ 100mg Vial<br>□ 300mg/kg | | □ Induction Dose: IV in 250ml of 0.9% NaCl at weeks 0, 2, and 6 weeks.<br>□ Maint. Dose: IV in 250ml of 0.9% NaCl every 8 weeks.<br>□ Maint. Dose: IV in 250ml of 0.9% NaCl every 6 weeks.<br>□ Other: _____ | | |
| □ **Rituxan** | □ 100mg/10ml vial<br>□ 500mg/50ml vial | | □ Infuse two doses of 100mg in 1 liter of 0.9% NaCl separated by 2 weeks.<br>□ Other: _____ | | |
| □ **Reclast** | □ 5mg/100ml | | □ 5mg/100ml Once every year.<br>□ Other: _____ | | |
| □ **Simponi Aria** | □ _____ mg/kg | | □ Inject 2 mg/kg intravenous (IV) infusion over 30 minutes at Weeks 0 and 4, then every 8 weeks thereafter<br>□ Other: _____ | | |

**Physician Signature:** _____ □ **DAW (Dispense as Written) Date:** _____

**Physician Name:** _____ **Phone:** _____ **Fax:** _____ **Office Contact:** _____

**Physician Address:** _____ **NPI:** _____ **DEA:**_____



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