W	1)/			natology 0-8008	Enrollmer	nt Fo	orm		
	Phar			305-0788					
	INFORMATI			PRESCRIBER IN	FORMATION				
		ving or send patient demogra							
Patient Na	me		<u> </u>	Prescriber Name					
Address				DEA					
Address 2				NPI					
City, State	, Zip	Mobile Phone		Address					
Home Pho	ne			City, State, Zip					
DOR	Last Fo	our of SSGender	r	Phone	Fax				
Language	Preference	se fax or email relevant clinic		Contact Person					
Clinical Di	agnosis: pleas	se fax or email relevant clinic	al notes, l	abs, tests, and previous	medical history to expedi	te prior aut	horization		
Diagnosis /				atment Date: TB/PPD Test Yes No Results					
				: currently on therapy? □ Y □ N Weightkg/lbs Heightcm/in nt terminate current therapy upon start of new prescription? □ Y □ N					
nas patient	been previously								
Туре	Medication	Dose/Strength	PRESCR		rections	Quantity	Refill		
Type	Ticulculon	□ 200mg Starter Kit (6x 200mg	PFS)	□ Inject 400mg SQ once.		Quantity			
	🗆 Cimzia	□ 2 x 200mg Prefilled Syringe		 Inject 200mg SQ once e 	•	□ 4-week	□ 11 □ <u> </u>		
				Inject 400mg SQ once e	very 4 weeks	supply			
		25mg Prefilled Syringe		Inject 25mg twice week					
	Enbrel	50mg/ ml Sureclick Autoinject	or	Inject 50mg SQ once we Deter	eekly	□ 4-week	□ 11 □		
TNF		50mg Prefilled Syringe		Other		supply			
Blocker						-			
		□ 40mg/0.4 ml Pen			□ Inject 40mg SQ every other week				
	🗆 Humira CF	□ 40mg/0.4 ml Prefilled Syringe		 Inject 40mg SQ once we Inject 80mg SQ on day 	4-week supply	□ 11 □			
		 Psoriasis Starter Pack 		then inject 40mg every					
		Crohn's Starter Pack			1 then inject 80mg on day 15	starter			
				then start maintenance		pack			
	Inflectra	100mg/20 ml vial							
	Remicade	□ 100mg/ 20 ml vial		□					
				□		□ 11 □			
	Simponi	 50mg/0.5ml Prefilled Syringe 50mg/0.5ml Autoinjector 		Inject 50mg SQ once a	□ 4-week	□ 1 □ 2 □ 3 □ 4 □ 5			
					supply	□ 11 □			
	Simponi	 50mg/4 ml single-use vial 162mg/0.9 ml PFS 		□ 2mg/kg IV over 30 minu	□ 4-week				
	Aria			then every 8 weeks ther 2 mg/kg over 30 minutes	supply	□ 11 □			
				 Inject 1 syringe SQ once 	□ 4-week				
IL-6		IV infusion B0mg/4 ml (20mg/ml) 200mg/10ml (20mg/ml) 400mg/20ml (20mg/ml) in a single dose		□ Inject 1 Syringe SQ every other week		supply			
Antagonist	Actemra					□ 11 □ <u> </u>			
							□ 11 □		
				□					
		vial for further dilution prior to I							
	🗆 Kevzara	□ 150mg prefilled Syringe		□ 150mg SQ once every 2 weeks		□ 4-week			
		□ 200mg prefilled Syringe		□ 200mg SQ once every 2	supply				
	Cosentyx	 150mg/ml single use Sensoready pen 150mg/ml single-use prefilled syringe 300mg lyophilized powder in a single 		□ 150mg SQ at weeks 0,1,2,3, & 4 and every 4		□ 4-week supply	□ 1 □ 2 □ 3 □ 4 □ 5		
IL-17A				weeks thereafter	□ 11 □				
Antagonist				□ 150mg SQ every 4 week					
	🗆 Taltz	use vial for reconstitution 80mg Auto-Injector Starter Kit (3 pens)		□ 300mg SQ every 4 week					
		 80mg Auto-Injector Starter Nit (Spens) 80mg Auto-Injector (2 pens) 80mg Auto-Injector (1 pen) 80mg Prefilled Syringe (1 syringe) 		160mg SQ on day 1, the weeks thereafter	□ 4-week				
				80mg SQ every 4 weeks	supply	· · · · ·			
IL-12,23	Stelara	45 mg Prefilled Syringe		Inject SQ weeks 0,4, and	□ 4-week				
Antagonist		90 mg Prefilled Syringe		Inject 1 syringe SQ ever	supply				
IL-23 Antagonist	Tremfya	□ 100 mg/ml Prefilled Syringe		Inject 100mg SQ at wee Inject 100mg SQ at wee	□ 4-week				
Antagonist T cell Co-		 100 mg/ml Pen 125 mg/ml Prefilled Syringe 		 Inject 100mg SQ every 3 Inject 125 mg SQ once 1 	supply				
stimulation			or (pen)	□ Infuse mg IV ever	□ 4-week				
Modulator		□ 250mg/ 15ml vial (IV only)		ing iv even	,	supply			
	·	· · · · · · · · · · · · · · · · · · ·		•		<u> </u>	•		
Ship to: 🗆	Patient 🗆 Office	Other		Date:	Need by Date				

* Prescriber Authorization: I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s) and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorizations forms and the receipt and submission of patient tab values and other patient data, in the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize the pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

Prescriber's Signature:

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Date:

	Whole Health	•	Rheumatology Enrollment Form Fax: 949-340-8008						
VV	Pharmacy	Fax: 949 Phone: 9							
PATIENT IN	ORMATION			PRESCRIBE	R INFOR	MATION			
	e the following or send	patient demograph	ic sheet						
					me				
Address									-
Address 2				NPI					
City, State, Zip	oMobile F			Address					
Home Phone	Mobile F	Phone			n				
DOB Last Four of SS Gender				Phone	Ρ	Fax			_
	erence			Contact Perso	on	i ux			_
Clinical Diagno	osis: please fax or emai	il relevant clinical no	otes, labs,	, tests, and prev	ious medio	cal history to e	xpedite prior a	uthorizati	ion
Diagnosis / ICD 10:		P	rior Treatm	nent Date:		TB/PPD Test	Yes 🗆 No Results		
	is or Years with Disease	I	s patient ci	urrently on therap	/? □ Y □ N	Weight	kg/lbs	Height	cm/in
	n previously treated? Y			terminate current					
T-Score Results:			story of Fra						
			,	ION INFORMAT	ION				
Туре	Medication	Dose/Streng			Directions		Quantity	F	Refill
CD 20-directed									□ 3 □ 4 □ 5
cytolytic antibody	Rituxan	□10mg /ml		□			□		
PDE 4 inhibitor	Otezla	Starter Pack		Take as directe			1 pack		□ 3 □ 4 □ 5
		30mg tablets		Take 1 tablet P	,		60 tablets		
JAK inhibitor	Olumiant Dumiant 2 mg tablets			Take 2mg PO o	nce daily		□ 30 tablets		□ 3 □ 4 □ 5
	Rinvoq 15 mg tablet		Take 15mg PO once daily		□ 30 tablets	□ 1 □ 2 □ 11 □	□ 3 □ 4 □ 5		
	Xeljanz Smg tablets			Take 5mg PO twice daily			60 tablets		□ 3 □ 4 □ 5
	Xeljanz XR 11mg tablets			Take 11mg PO once daily			□ 30 tablets		□ 3 □ 4 □ 5
	🗆 Forteo	□ 600 mcg/2.4 ml P	refilled	□ Inject 20 mcg S	SO as directe	d once daily	□ 4-week		□ 3 □ 4 □ 5
rhPTH (1-34)	 BD Ultra Fine Pen Syringe 		i ci ilicu		supply				
PTH1R agonist	Tymlos BD Ultra Fine Pen Needles		ringe	□ Inject 80 mcg SQ once daily			4-week supply	□ 1 □ 2 □ 11 □	□ 3 □ 4 □ 5
RANK L inhibitor	Prolia Prolia Gomg Prefilled		ringe	□ Inject 60mg SQ once every 6 months				□ 11 □	□ 3 □ 4 □ 5
BLyS inhibitor	🗆 Benlysta	□ 120 mg/5ml single vial			10mg/kg IV at 2-week intervals for the first 3 doses and at 4-week intervals thereafter			□ 1 □ 2 □ 11 □	□ 3 □ 4 □ 5
		400mg/20ml singl	e-dose				,		
		vial		200mg SQ once	e weekly				
	 200mg/ml sing prefilled autoir 200mg/ml sing prefilled syring 		ector dose						
Interferon	Saphnelo	 a 300mg/2ml Single 	e-dose	 Infuse 300ma i 	ntravenously	over 30 minutes	□ 4-week	□ 1 □ 2	□ 3 □ 4 □ 5
Receptor		vial		every 4 weeks			supply	□ 11 □_	
Antagonist, Type I Pegylated uric	Kashasa	0							<u> </u>
acid specific	🗆 Krystexxa	□ 8mg/ml vial		 8mg given as a week for chroni 		is infusion every 2			□ 3 □ 4 □ 5
enzyme Bisphosphonate	Zoledronic	□ 5mg in a 100 ml r	oody to	□ Infuse 5mg/10		30 minutos		_ 1 _ `	□ 3 □ 4 □ 5
Dispriosprioriate	Acid	infuse solution	eauy-to-			50 minutes	<u> </u>		030403
Corticosteroid		s Ing tablets 2mg tablets		□			□		□ 3 □ 4 □ 5
Interleukin-1B blocker	🗆 Ilaris	is 150mg/mL sdv		4mg/kg SQ every 4 weeks			□ 4-week supply		□ 3 □ 4 □ 5
Other								□ 1 □ 2	□ 3 □ 4 □ 5
							<u> </u>		
Shin to: 🗆 Patio	nt 🗆 Office 🗆 Other		г	Date:		Need by Date	2		
* Prescriber Authoriza my authorized agent, incl	tion: I authorize this pharmacy and its reputed by the second s	thorizations forms and the receipt ar	d agent to secur nd submission of	e coverage and initiate the ir patient tab values and other	patient data, in th	orization process for my p e event that this pharmacy	atient(s) and to sign any ne determines that it is unab	ecessary forms or le to fulfill this pr	n my behalf as escription, I
	n permitted Dispense as Writter			,					
Prescriber's Signat	ure:					Date:			
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