Rheumatology Enrollment Form

Whole Health Pharmacy

Fax: 949-340-8008
Phone: 949-305-0788

PATIENT INFORMATION

*Please complete the following or **send patient demographic sheet***

Patient Name _____
Address _____
Address 2 _____
City, State, Zip _____
Home Phone _____ Mobile Phone _____
DOB _____Last Four of SS _____ Gender _____
Language Preference _____

PRESCRIBER INFORMATION

Prescriber Name _____
DEA _____
NPI _____
Address _____
City, State, Zip _____
Phone _____ Fax _____
Contact Person _____

Clinical Diagnosis: please fax or email relevant clinical notes, labs, tests, and previous medical history to expedite prior authorization

Diagnosis / ICD 10:		Prior Treatment Date:	TB/PPD Test □ Yes □ No Results
Date of Diagnosis or Years with Disease		Is patient currently on therapy? □ Y □ N	Weight _____kg/lbs Height _____cm/in
Has patient been previously treated? □ Y □ N		Will patient terminate current therapy upon start of new prescription? □ Y □ N	

PRESCRIPTION INFORMATION

Type	Medication	Dose/Strength	Directions	Quantity	Refill
TNF Blocker	□ Cimzia	□ 200mg Starter Kit (6x 200mg PFS) □ 2 x 200mg Prefilled Syringe	□ Inject 400mg SQ once. Repeat weeks 2 & 4 □ Inject 200mg SQ once every 2 weeks □ Inject 400mg SQ once every 4 weeks	□ 4-week supply	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ _____
	□ Enbrel	□ 25mg Prefilled Syringe □ 50mg/ ml Sureclick Autoinjector □ 50mg Prefilled Syringe	□ Inject 25mg twice weekly. 72 -96 hours apart □ Inject 50mg SQ once weekly □ Other _____	□ 4-week supply	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ _____
	□ Humira CF	□ 40mg/0.4 ml Pen □ 40mg/0.4 ml Prefilled Syringe □ Psoriasis Starter Pack □ Crohn's Starter Pack	□ Inject 40mg SQ every other week □ Inject 40mg SQ once weekly □ Inject 80mg SQ on day 1 then inject 40mg on day 8 then inject 40mg every other week thereafter □ Inject 160mg SQ on day 1 then inject 80mg on day 15 then start maintenance dose	□ 4-week supply □ 1 starter pack	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ _____
	□ Inflectra	□ 100mg/20 ml vial	□ _____	□ _____	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ _____
	□ Remicade	□ 100mg/ 20 ml vial	□ _____	□ _____	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ _____
	□ Simponi	□ 50mg/0.5ml Prefilled Syringe □ 50mg/0.5ml Autoinjector	□ Inject 50mg SQ once a month	□ 4-week supply	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ _____
	□ Simponi Aria	□ 50mg/4 ml single-use vial	□ 2mg/kg IV over 30 minutes at weeks 0 and 4, then every 8 weeks thereafter □ 2mg/kg over 30 minutes every 8 weeks	□ 4-week supply	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ _____
IL-6 Antagonist	□ Actemra	□ 162mg/0.9 ml PFS	□ Inject 1 syringe SQ once weekly □ Inject 1 Syringe SQ every other week	□ 4-week supply	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ _____
		IV infusion □ 80mg/4 ml (20mg/ml) □ 200mg/10ml (20mg/ml) □ 400mg/20ml (20mg/ml) in a single dose vial for further dilution prior to IV infusion	□ _____	□ _____	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ _____
	□ Kevzara	□ 150mg prefilled Syringe □ 200mg prefilled Syringe	□ 150mg SQ once every 2 weeks □ 200mg SQ once every 2 weeks	□ 4-week supply	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ _____
IL-17A Antagonist	□ Cosentyx	□ 150mg/ml single use Sensoready pen □150mg/ml single-use prefilled syringe □ 300mg lyophilized powder in a single use vial for reconstitution	□ 150mg SQ at weeks 0,1,2,3, & 4 and every 4 weeks thereafter □ 150mg SQ every 4 weeks □ 300mg SQ every 4 weeks	□ 4-week supply	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ _____
	□ Taltz	□ 80mg Auto-Injector Starter Kit (3 pens) □ 80mg Auto-Injector (2 pens) □ 80mg Auto-Injector (1 pen) □ 80mg Prefilled Syringe (1 syringe)	□ 160mg SQ on day 1, then followed by 80mg every 4 weeks thereafter □ 80mg SQ every 4 weeks	□ 4-week supply	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ _____
IL-12,23 Antagonist	□ Stelara	□ 45 mg Prefilled Syringe □ 90 mg Prefilled Syringe	□ Inject SQ weeks 0,4, and every 12 weeks thereafter □ Inject 1 syringe SQ every 12 weeks	□ 4-week supply	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ _____
IL-23 Antagonist	□ Tremfya	□ 100 mg/ml Prefilled Syringe □ 100 mg/ml Pen	□ Inject 100mg SQ at weeks 0 and 4 (starter) □ Inject 100mg SQ every 8 weeks	□ 4-week supply	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ _____
T cell Co-stimulation Modulator	□ Orencia	□ 125 mg/ml Prefilled Syringe □ 125 mg/ml Clickjet Autoinjector (pen) □ 250mg/ 15ml vial (IV only)	□ Inject 125 mg SQ once weekly □ Infuse _____mg IV every 4 weeks	□ 4-week supply	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ _____

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.

□ Product Substitution permitted □ Dispense as Written

Prescriber's Signature: _____ Date: _____

Rheumatology Enrollment Form

Whole Health Pharmacy

Fax: 949-340-8008
Phone: 949-305-0788

PATIENT INFORMATION

*Please complete the following or **send patient demographic sheet***

Patient Name _____
Address _____
Address 2 _____
City, State, Zip _____
Home Phone _____ Mobile Phone _____
DOB _____Last Four of SS _____ Gender _____
Language Preference _____

PRESCRIBER INFORMATION

Prescriber Name _____
DEA _____
NPI _____
Address _____
City, State, Zip _____
Phone _____ Fax _____
Contact Person _____

Clinical Diagnosis: please fax or email relevant clinical notes, labs, tests, and previous medical history to expedite prior authorization

Diagnosis / ICD 10:		Prior Treatment Date:	TB/PPD Test □ Yes □ No Results
Date of Diagnosis or Years with Disease		Is patient currently on therapy? □ Y □ N	Weight _____kg/lbs Height _____cm/in
Has patient been previously treated? □ Y □ N		Will patient terminate current therapy upon start of new prescription? □ Y □ N	
T-Score Results:		History of Fractures:	

PRESCRIPTION INFORMATION

Type	Medication	Dose/Strength	Directions	Quantity	Refill
CD 20-directed cytolytic antibody	□ Rituxan	□10mg /ml	□ _____	□ _____	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ _____
PDE 4 inhibitor	□ Otezla	□ Starter Pack □ 30mg tablets	□ Take as directed □ Take 1 tablet PO twice daily	□ 1 pack □ 60 tablets	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ _____
JAK inhibitor	□ Olumiant	□ 2 mg tablets	□ Take 2mg PO once daily	□ 30 tablets	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ _____
	□ Rinvoq	□ 15 mg tablets	□ Take 15mg PO once daily	□ 30 tablets	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ _____
	□ Xeljanz	□ 5mg tablets	□ Take 5mg PO twice daily	□ 60 tablets	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ _____
	□ Xeljanz XR	□ 11mg tablets	□ Take 15mg PO once daily	□ 30 tablets	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ _____
rhPTH (1-34)	□ Forteo □ BD Ultra Fine Pen Needles	□ 600 mcg/2.4 ml Prefilled Syringe	□ Inject 20 mcg SQ as directed once daily	□ 4-week supply	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ _____
PTH1R agonist	□ Tymlos □ BD Ultra Fine Pen Needles	□ 80mcg Prefilled Syringe	□ Inject 80 mcg SQ once daily	□ 4-week supply	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ _____
RANK L inhibitor	□ Prolia	□ 60mg Prefilled Syringe	□ Inject 60mg SQ once every 6 months		□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ _____
BLyS inhibitor	□ Benlysta	□ 120 mg/5ml single-dose vial □ 400mg/20ml single-dose vial □ 200mg/ml single-dose prefilled autoinjector □ 200mg/ml single-dose prefilled syringe	□ 10mg/kg IV at 2-week intervals for the first 3 doses and at 4-week intervals thereafter □ 200mg SQ once weekly	□ 4-week supply	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ _____
Pegylated uric acid specific enzyme	□ Krystexxa	□ 8mg/ml vial	□ 8mg given as an intravenous infusion every 2 week for chronic Gout	□ _____	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ _____
Bisphosphonate	□ Zoledronic Acid	□ 5mg in a 100 ml ready-to-infuse solution	□ Infuse 5mg/100 ml IV over 30 minutes	□ _____	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ _____
Corticosteroid	□ Rayos	□ 1mg tablets □ 2mg tablets □ 3mg tablets	□ _____	□ 30 tablets □ 60 tablets □ 90 tablets	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ _____
Other	□ _____	□ _____	□ _____	□ _____	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ _____

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.

□ Product Substitution permitted □ Dispense as Written

Prescriber's Signature: _____ Date: _____