Whole Health Pharmacy

Rheumatology Enrollment Form

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: ____________________

CONFIDENTIALITY STATEMENT: This communication is intended for use of the individual or entity to which it is addressed and may contain information that is privileged, confidential, and exempt from disclosure under applicable law If the reader of this communication is not the intended recipient or the employee or agent responsible for delivery of the communication, you are hereby notified that any dissemination distribution, or copying of the communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone.

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Address 2 ____
City, State, Zip ____
Home Phone _______________ Mobile Phone _______________
DOB ___________Last Four of SS ___________ Gender ______
Language Preference _____________________________________

PRESCRIBER INFORMATION

Prescriber Name ____
DEA ____
NPI ____
Address ____
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Phone ____________________ Fax _________________________
Contact Person ____

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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 11mg 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: ____________________

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