Rheumatology Enrollment Form

Please fax completed order form to 972-499-9210

Please include demographics, most recent H&P and/or clinical notes, medication list and lab results.

Patient's name: _____ Date of birth: _____ Phone #: _____

Allergies: _____ Weight: _____ Height: _____

DIAGNOSIS & CLINICAL INFORMATION

ICD 10 Code (Required)

Date of Diagnosis: _____ ☐ H20.0 Iridocyclitis (Uveitis), Unspecified Acute and Subacute ☐ H20.9 Unspecified Iridocyclitis

☐ L40.50 Arthropathic Psoriasis, Unspecified (Psoriatic Arthritis) ☐ M05.9 Rheumatoid Arthritis with Rheumatoid Factor, Unspecified

☐ M06.00 Rheumatoid Arthritis without Rheumatoid Factor, Unspecified ☐ M06.9 Rheumatoid Arthritis, Unspecified

☐ M08.00 Unspecified Juvenile Rheumatoid Arthritis of Unspecified Site ☐ M31.5 Giant Cell Arthritis with Polymyalgia Rheumatica

☐ M31.6 Other Giant Cell Arthritis ☐ M45.9 Ankylosing Spondylitis, Unspecified ☐ Other: _____

Active TB is ruled out: ☐ Yes ☐ No Date: _____ Hep B ruled out/treated: ☐ Yes ☐ No Date: _____

Allergies: _____

Additional Clinical Information: _____

Patient Preferred Location:

☐ **Lewisville**
2790 Lake Vista Dr.
Lewisville, TX 75067

☐ **Dallas**
11970 N. Central Expy. #630
Dallas, TX 75243

☐ **Plano**
5425 Spring Creek Pkwy. #135
Plano, TX 75024

☐ **Rowlett**
6800 Heritage Pkwy. #105
Rowlett, TX 75087

☐ **Denton**
2800 Shoreline Dr. #270
Denton, TX 76210

PRESCRIPTION

MEDICATION	DOSE	DIRECTIONS & QUANTITY	
Actemra®	☐ Vials ☐ Pre-filled Syringe	☐ **IV:** Infuse _____ mg OR _____ mg/kg via IV every 4 weeks ☐ **SQ:** Inject 162mg SQ every other week ☐ **MAINTENANCE**: Inject 162mg SQ every week	☐ PRN refills for one year
Cimzia®	☐ Pre-filled Syringe ☐ Lyophilized Powder	☐ **INITIAL:** Inject 400mg SQ at day 0, day 14, and day 28 ☐ **MAINTENANCE:** Inject 400mg SQ every 4 weeks ☐ **MAINTENANCE**: Inject 200mg SQ every 2 weeks	☐ PRN refills for one year
Cosentyx™	☐ Sensoready Pen ☐ Pre-filled Syringe	☐ **INITIAL:** Inject 150mg SQ on week 0, 1, 2, 3, and 4 ☐ **MAINTENANCE:** Inject 150mg SQ every 4 weeks ☐ **INITIAL:** Inject 300mg SQ on week 0, 1, 2, 3, and 4 ☐ **MAINTENANCE**: Inject 300mg SQ every 4 weeks	☐ PRN refills for one year
Enbrel®	☐ SureClick® Pen 50mg ☐ Pre-filled Syringe ☐ 25mg ☐ 50mg ☐ Vials 25mg	☐ Inject 50mg SQ every week ☐ Inject 25mg SQ twice weekly 72-96 hours apart	☐ PRN refills for one year
Humira®	☐ Pen ☐ Pre-filled Syringe	☐ **UVEITIS INITIAL:** Inject 80mg SQ on day 1, 40mg on day 8, then 40mg every other week ☐ **MAINTENANCE:** Inject 40mg SQ every other week ☐ **MAINTENANCE:** Inject 40mg SQ weekly	☐ PRN refills for one year
Orencia®	☐ Vials ☐ Pre-filled Syringe ☐ ClickJet™	☐ **INITIAL:** Infuse _____ mg via IV, then inject 125mg SQ within 24 hours ☐ **MAINTENANCE**: Inject 125mg SQ weekly	☐ PRN refills for one year
Simponi®	☐ SmartJect® Pen ☐ Pre-filled Syringe	☐ Inject 50mg SQ once monthly	☐ PRN refills for one year
Stelara®	☐ Pre-filled Syringe Weight Required: _____	☐ **INITIAL:** Inject 45mg SQ on day 0 and day 28 ☐ **MAINTENANCE:** Inject 45mg SQ every 12 weeks ☐ **INITIAL:** Inject 90mg SQ on day 0 and day 28 ☐ **MAINTENANCE:** Inject 90mg SQ every 12 weeks ****Weight must be ≥ 220lbs***	☐ PRN refills for one year
Benlysta®	10mg/kg	☐ **LOADING:** Infuse _____ mg at weeks 0, 2, and 4 ☐ **MAINTENANCE:** Infuse _____ mg every 4 weeks	
OTHER			

PRESCRIBER INFORMATION

Prescriber Name: _____ Specialty: _____

Address: _____ City/State/Zip: _____

Contact Name: _____ Phone #: _____ Fax #: _____

Date: _____ NPI #: _____ ☐ PRN Refills X 1 year

Prescriber Signature Below:

_____

A biosimilar equivalent drug product may be dispensed unless the practitioner indicates the words "Brand Necessary" or "Brand Medically Necessary" on the face of the prescription.