



# VITAL CARE RX

*Tailored Therapy, Trusted Care*

## Rheumatology Enrollment Form

Phone: (877)229-1724 | Fax: (877)229-1725

### PATIENT INFORMATION

(Complete the following or send patient demographic sheet.)

Please fax copy of patient's insurance card including both sides

Name: \_\_\_\_\_

DOB: \_\_\_\_\_ Gender: M / F Height: \_\_\_\_\_ Wt: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Alternate Phone: \_\_\_\_\_

Last 4 digits SS#: \_\_\_\_\_ Email: \_\_\_\_\_

### PRESCRIBER INFORMATION

Prescriber Name: \_\_\_\_\_

State Lic. #: \_\_\_\_\_ NPI: \_\_\_\_\_

Facility Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Contact: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

### CLINICAL INFORMATION – STATEMENT OF MEDICAL NECESSITY

Diagnosis: ☐ M06.9 Rheumatoid Arthritis ☐ L40.59 Psoriatic Arthritis ☐ M08.00 Juvenile Rheumatoid Arthritis  
☐ M45.9 Ankylosing Spondylitis ☐ Other ICD 10 code: \_\_\_\_\_

Please indicate current or previous treatments and treatment duration below:

☐ NSAIDS Duration: \_\_\_\_\_ ☐ Corticosteroids Duration: \_\_\_\_\_  
☐ Methotrexate Duration: \_\_\_\_\_ ☐ Azathioprine Duration: \_\_\_\_\_  
☐ Sulfasalazine Duration: \_\_\_\_\_ ☐ 5 – ASA Duration: \_\_\_\_\_  
☐ Celebrex Duration: \_\_\_\_\_ ☐ Other - \_\_\_\_\_ Duration: \_\_\_\_\_

Other medications patient is currently taking: \_\_\_\_\_

TB/PPD Test given? ☐ Yes ☐ No Results \_\_\_\_\_ Date \_\_\_\_\_ Allergies \_\_\_\_\_

### PRESCRIPTION INFORMATION

Medication	Directions	Quantity	Refills
Actemra® <input type="checkbox"/> 162 mg Prefilled Syringe	Prefilled Syringe <input type="checkbox"/> (> 220 lbs) Inject 162mg SC once a week Prefilled Syringe <input type="checkbox"/> (< 220 lbs) Inject 162mg SC every other week	28 day supply	
Cimzia® <input type="checkbox"/> 200 mg Prefilled Syringe <input type="checkbox"/> LYO Powder 200mg vial	<input type="checkbox"/> Initial dose of 400 mg SC at weeks 0, 2, 4 <input type="checkbox"/> Maintenance dose of 400 mg SC every 4 weeks <input type="checkbox"/> Maintenance dose of 200mg SC every other week	28 day supply	
Cosentyx® <input type="checkbox"/> 150 mg Sensoready Pen <input type="checkbox"/> 150 mg Prefilled Syringe	Initial Dose: Inject <input type="checkbox"/> 300mg or <input type="checkbox"/> 150 mg SC week 0,1,2,3,4 Maintenance: Inject <input type="checkbox"/> 300mg or <input type="checkbox"/> 150mg SC every 4 weeks	28 day supply 28 day supply	0
Enbrel® <input type="checkbox"/> 50 mg Mini <input type="checkbox"/> 50 mg Sureclick <input type="checkbox"/> 50 mg Prefilled Syringe <input type="checkbox"/> 25 mg Prefilled Syringe <input type="checkbox"/> 25 mg Vials	<input type="checkbox"/> Inject 50mg SC once a week <input type="checkbox"/> Inject 25mg SC twice a week 72 - 96 hours apart	28 day supply	
Humira® <input type="checkbox"/> 40 mg Pen <input type="checkbox"/> 40 mg Prefilled Syringe	<input type="checkbox"/> Inject 40 mg SC every other week <input type="checkbox"/> Inject 40 mg SC once a week	28 day supply	
Orencia® <input type="checkbox"/> 125 mg Autoinjector <input type="checkbox"/> 125 mg Prefilled Syringe	<input type="checkbox"/> Inject 125mg SC once a week	28 day supply	
Otezla® <input type="checkbox"/> Starter Pack <input type="checkbox"/> 30 mg tab	<input type="checkbox"/> Titrate as directed on package <input type="checkbox"/> Take one tablet by mouth twice daily	1 starter pack 30 day supply	0
Simponi® <input type="checkbox"/> 50 mg SmartJect <input type="checkbox"/> 50 mg Prefilled Syringe	<input type="checkbox"/> Inject 50 mg SC once a month as directed	28 day supply	
Stelara® <input type="checkbox"/> 45 mg Prefilled Syringe <input type="checkbox"/> 90 mg Prefilled Syringe	<input type="checkbox"/> (< 220 lbs) Inject 45 mg on day 0 then week 4, followed by 45 mg dose every 12 weeks <input type="checkbox"/> (> 220 lbs) Inject 90 mg on day 0 then week 4, followed by 90 mg dose every 12 weeks	28 day supply	
Xeljanz® <input type="checkbox"/> 5 mg tablet	<input type="checkbox"/> Take one (5mg) tablet by mouth twice daily	30 day supply	
Xeljanz XR® <input type="checkbox"/> 11 mg tablet	<input type="checkbox"/> Take one (11mg) tablet by mouth once daily	30 day supply	

Ship Medications To: ☐ Physician's Clinic ☐ Patient's Home

Injection Training Needed: ☐ Yes ☐ No

Prescriber Signature \_\_\_\_\_ Date \_\_\_\_\_ Brand Name Required? ☐ Yes

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 and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms, financial treatment and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of this product to another pharmacy of the patient's choice or in the patient's insurer's provider network.