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