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	
Benlysta®	☐ 200 mg PFS ☐ 200 mg Autoinjector	☐ SubQ Administration: Inject 200 mg SC once weekly		0
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 Maintenance: Inject ☐ 300mg or ☐ 150mg SC every 4 weeks	28 day supply 28 day supply	0
Enbrel®	☐ 50 mg Sureclick Autoinjector ☐ 50 mg PFS ☐ 50 mg mini ☐ 25 mg PFS ☐ 25 mg Vials	☐ Inject SC twice a week 72 - 96 hours apart ☐ Inject SC once a week ☐ Inject ____ mg (0.8mg/kg X _____kg SC every week (≤ 63 kg) ☐ Other:	28 day supply	
Humira®	☐ 40 mg Pen ☐ 40 mg PFS ☐ 40 mg CF Pen ☐ 40 mg CF PFS	☐ Inject 40 mg SC every other week ☐ Inject 40 mg SC once a week	28 day supply	
Kevzara®	☐ 200 mg PFS ☐ 150 mg PFS	☐ Inject 200 mg SC once every two weeks ☐ Inject 150 mg SC once every two weeks		
Orencia®	☐ 125 mg Autoinjector ☐ 125 mg Prefilled Syringe	☐ Inject 125mg SC once a week	28 day supply	
Otezla®	☐ Starter Pack ☐ 30 mg tab	☐ Titrate as directed on package ☐ Take one tablet by mouth twice daily	1 starter pack 30 day supply	0
Rinvoq™	☐ 15 mg ER tablet	☐ Take one (15mg) tablet PO once daily ☐ Other:	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	
Taltz®	☐ 80 mg Autoinjector Pen ☐ 80 mg Prefilled Syringe	☐ Initial Dose: Inject 160 mg SC at week 0 ☐ Maintenance Dose: Inject 80 mg SC every 4 weeks		
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.