



# VITAL CARE RX

*Tailored Therapy, Trusted Care*

## Rheumatology IV 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:

☐ 714.0 Rheumatoid Arthritis

☐ 696.0 Psoriatic Arthritis

☐ 714.3 Juvenile Rheumatoid Arthritis

☐ 720.0 Ankylosing Spondylitis

☐ Other - \_\_\_\_\_

Please indicate current or previous treatments and treatment duration below:

☐ NSAIDS

Duration: \_\_\_\_\_

☐ Methotrexate

Duration: \_\_\_\_\_

☐ Azulfidine

Duration: \_\_\_\_\_

☐ Celebrex

Duration: \_\_\_\_\_

☐ Corticosteroids

Duration: \_\_\_\_\_

☐ Azathioprine

Duration: \_\_\_\_\_

☐ 5 – ASA

Duration: \_\_\_\_\_

☐ Other - \_\_\_\_\_

Duration: \_\_\_\_\_

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

TB/PPD Test given or intended to be given before start?

☐ Yes

☐ No

Allergies: \_\_\_\_\_

Weight: \_\_\_\_\_

Height \_\_\_\_\_

BSA \_\_\_\_\_

Expected date of first/next dose: \_\_\_\_\_

Date of last dose: \_\_\_\_\_

### PRESCRIPTION INFORMATION

Medication		Directions	Quantity	Refills
Actemra®	<input type="checkbox"/> 20 mg/ml vial	<input type="checkbox"/> Initial Dose: 4mg/kg every 4 weeks. Max dose of 800mg/infusion <input type="checkbox"/> Maintenance Dose: _____mg/kg (_____mg) every 4 weeks. Max dose of 800mg/infusion	4 week supply	
Orencia®	<input type="checkbox"/> 500 mg (less than 60 kg) <input type="checkbox"/> 750 mg (60-100 kg) <input type="checkbox"/> 1000 mg (over 100 kg) <input type="checkbox"/> Juvenile arthritis 10 mg/kg if less than 75 kg	<input type="checkbox"/> Initial Dose: Infuse IV at weeks 0, 2, and 4 weeks. <input type="checkbox"/> Maintenance Dose: Infuse IV every 4 weeks.	4 week supply	
Remicade®	<input type="checkbox"/> 100 mg vial	<input type="checkbox"/> Initial Dose: Infuse _____mg/kg (_____mg) IV at weeks 0, 2, and 6 weeks. <input type="checkbox"/> Maintenance Dose: Infuse _____mg/kg (_____mg) IV every _____ weeks.	QS	
Rituxan®	<input type="checkbox"/> 10 mg/ml vial	<input type="checkbox"/> Infuse 1000mg IV on day 1 and day 15. <input type="checkbox"/> Other: _____	2 week supply	
Simponi Aria®	<input type="checkbox"/> 50 mg/4 mL vial	<input type="checkbox"/> Initial Dose: Infuse 2mg/kg (_____mg) IV at weeks 0 and 4. <input type="checkbox"/> Maintenance Dose: Infuse 2mg/kg (_____mg) IV every 8 weeks.	QS	
Other:				

Special Instructions: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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.