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: 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 ☐ L40.5 Psoriatic Arthritis ☐ M08.00 Juvenile Rheumatoid Arthritis
☐ M45.9 Ankylosing Spondylitis ☐ Other - _____

Please indicate current or previous treatments and treatment duration below:

☐ NSAIDS Duration: _____ ☐ Corticosteroids Duration: _____
☐ Methotrexate Duration: _____ ☐ Azathioprine Duration: _____
☐ Azulfidine Duration: _____ ☐ 5 – ASA Duration: _____
☐ Celebrex 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®	☐ 20 mg/ml vial	☐ **Initial Dose:** 4mg/kg every 4 weeks. Max dose of 800mg/infusion ☐ **Maintenance Dose:** _____mg/kg (_____mg) every 4 weeks. Max dose of 800mg/infusion	4 week supply	
Orencia®	☐ 500 mg (less than 60 kg) ☐ 750 mg (60-100 kg) ☐ 1000 mg (over 100 kg) ☐ Juvenile arthritis 10 mg/kg if less than 75 kg	☐ **Initial Dose:** Infuse IV at weeks 0, 2, and 4 weeks. ☐ **Maintenance Dose:** Infuse IV every 4 weeks.	4 week supply	
Remicade®	☐ 100 mg vial	☐ **Initial Dose:** Infuse _____mg/kg (_____mg) IV at weeks 0, 2, and 6 weeks. ☐ **Maintenance Dose:** Infuse _____mg/kg (_____mg) IV every ____ weeks.	QS	
Rituxan®	☐ 10 mg/ml vial	☐ Infuse 1000mg IV on day 1 and day 15. ☐ Other:_____	2 week supply	
Simponi Aria®	☐ 50 mg/4 mL vial	☐ **Initial Dose:** Infuse 2mg/kg (_____mg) IV at weeks 0 and 4. ☐ **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.