Rheumatology Enrollment Form

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MAXOR® SPECIALTY

PATIENT INFORMATION

Patient Name _____
Date of Birth _____ ◯ Male ◯ Female
Street Address _____ Apt # _____
City _____ State _____ Zip _____
Phone-Primary _____ Secondary _____
◯ English ◯ Spanish ◯ Other _____
Email Address _____
Social Security # _____
◯ NKDA Known Drug Allergies _____
Weight _____ kg/lb Height _____ in/cm

Please attach front and back of patient's insurance cards

PHYSICIAN INFORMATION

Physician Name _____
NPI _____ License # _____
Office Contact _____
Street Address _____ Ste # _____
City _____ State _____ Zip _____
Phone _____ Fax _____

By signing this form, I authorize Maxor Specialty to act as my agent for prior authorizations & prescription reimbursement for the above listed patient.

Physician Signature _____
Date _____
◯ Dispense as written ◯ Product substitution permitted

** For Ohio patients, please only choose one (1) prescription/form.**

CLINICAL INFORMATION

Diagnosis: ◯ M06.9 Rheumatoid Arthritis ◯ L40.50 Psoriatic Arthritis ◯ M45.9 Ankylosing Spondylitis
◯ M32.10 Systemic Lupus Erythematosus ◯ L40.8 Psoriasis Moderate to Severe Plaque ◯ M81.0 Osteoporosis
◯ Other _____

Prior (FAILED): Medications _____ Length of Treatment _____ Reason for Discontinuing _____
Medications _____ Length of Treatment _____ Reason for Discontinuing _____

TB Test: ◯ Yes ◯ No Results: _____ Forteo/Prolia: T-Score: _____ Type _____ Date _____

PRESCRIPTION INFORMATION

CHECK TO ENROLL IN PATIENT ASSISTANCE PROGRAM ◯

MEDICATION	STRENGTH	DIRECTIONS	QTY	REFILLS
◯ **Actemra®**	◯ 4mg/kg ◯ 8mg/kg ◯ 162mg/0.9ml PFS	◯ Infuse IV over 1 hr every 4 wks ◯ <100kg inject 162mg SQ every other wk, then increase to every wk based on clinical response ◯ ≥100kg inject 162kg SQ every wk		
◯ **Benlysta®**	◯ 10mg/kg	◯ Infuse_____mg at wks 0, 2, and 4, then every 4 wks thereafter		
◯ **Cimzia®**	◯ Cimzia Starter Kit ◯ 200mg/1ml PFS (2)	**Initial Dose:** ◯ Inject 400mg SQ at wks 0,2,4 **Maintenance Dose:** ◯ Inject 200mg every other wk ◯ Inject 400mg SQ every 4 wks		
◯ **Cosentyx®**	◯ 2 pk (2X150mg)Pen/PFS ◯ 150mg (single) ◯ Pen ◯ PFS	**Initial Dose:** ◯ Inject 150mg SQ at wks 0, 1, 2, 3, 4 ◯ Inject 300mg SQ at wks 0, 1, 2, 3, 4 **Maintenance Dose:** ◯ Inject ◯ 150mg SQ every 4 wks ◯ Inject ◯ 300mg SQ every 4 wks		
◯ **Enbrel®**	◯ 50mg/ml Sureclick ◯ 50mg/ml PFS ◯ 25mg/0.5ml PFS ◯ 25mg Vial	◯ Inject 50mg SQ once a wk ◯ Inject 25mg SQ twice a wk (72-96 hrs apart) ◯ Other _____		
◯ **Humira®**	◯ 40mg ◯ Pen ◯ PFS	◯ Inject 40mg SQ every other wk ◯Other _____		
◯ **Orencia®**	◯125mg PFS ◯ 250mg Vial	◯ Inject 125mg SQ once a wk ◯ >100kg: 1000mg IV wks 0, 2, 4, then Q 4 wks starting wk 8 ◯ 60 - 100kg: 750mg IV wks 0, 2, 4, then Q 4 wks starting wk 8 ◯ < 60kg: 500mg IV wks 0, 2, 4, then Q 4 wks staring wk 8		
◯ **Otezla®**	◯ Starter Pack ◯ 30mg Tablet	◯ Take 1 Tablet on day 1 then twice daily as directed ◯ Take 1 tablet by mouth twice a day		
◯ **Remicade®**	◯ 100mg Vial	◯ Infuse _____mg/kg at wks 0, 2, and 6, then _____ wks thereafter		
◯ **Rituxan®**	◯ 500mg Vial	◯ Infuse 1000mg IV days 1 and 15, then _____ wks (no sooner than 16 wks)		
◯ **Simponi®**	◯ 2mg/kg ◯ 50mg	◯ Infuse IV over 30 min, repeat dose in 4 wks, then every 8 wks thereafter ◯ Inject 50mg SQ monthly		
◯ **Stelera®**	◯ 45mg ◯ 90mg	**Initial Dose:** ◯ 45mg SQ; repeat dose in 4 wks ◯ >100kg (220lbs) and with plaque psoriasis 90mg SQ; repeat dose in 4 wks **Maintenance Dose:** ◯ 45mg Q 12 wks starting at 16 wks ◯>100kg(220lbs) and with plaque psoriasis 90mg Q 12 wks starting at 16 wks		
◯ **Xeljanz®**	◯ 5mg Tablet ◯ 11mg XR Tablet	◯ Take 5mg by mouth twice a day ◯ Take 11mg by mouth once a day		
◯ **Other**				

Date meds needed: _____ ◯ New ◯ Refill
Ship to: ◯ Patient's home ◯ Physician's Office ◯ Other _____