**Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy.** Prescribers are reminded patients may choose any pharmacy of their choice.

# Twin Oaks Specialty Pharmacy

Fax: 855-909-TOSP (8677)

# RHEUMATOLOGY ENROLLMENT FORM

Date Medication Needed: ________ **Ship To:** Patient's Home Prescriber's Office Pick-up: Injection training by pharmacy?

## 1: Patient Information
Please FAX copy of front and back of prescription insurance card

Patient Name: ________ Birthdate: ________ Sex: Male Female Height: ________ Weight: ________ lbs. kg.

Soc. Sec. #: ________ Preferred Phone: ________ Known Allergies: ________

Address: ________ City: ________ State: ________ Zip: ________

Alternate Caregiver Name: ________ Preferred Phone: ________

## 2: Prescriber Information

Provider Name: ________ DEA#: ________ NPI#: ________ Tax ID#: ________

Address: ________ Phone: ________ Fax: ________

City, State, Zip: ________ Key Contact: ________ Phone: ________

## 3: Diagnosis/Clinical Information
*Please FAX recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization*

| PREVIOUS THERAPIES: | Tried & Failed (Duration): | Not Tolerated: | Contraindication: |
|---|---|---|---|
| ☐ Methotrexate | ☐ (________) | ☐ | ________ |
| ☐ Plaquenil | ☐ (________) | ☐ | ________ |
| ☐ Sulfasalazine | ☐ (________) | ☐ | ________ |
| ☐ Meloxicam | ☐ (________) | ☐ | ________ |
| ☐ Naproxen / Aleve | ☐ (________) | ☐ | ________ |
| ☐ Tramadol | ☐ (________) | ☐ | ________ |
| ☐ Enbrel | ☐ (________) | ☐ | ________ |
| ☐ Humira | ☐ (________) | ☐ | ________ |
| ☐ Cimzia | ☐ (________) | ☐ | ________ |
| ☐ ________ | ☐ (________) | ☐ | ________ |

- ☐ H20.9 Unspecified Iridocyclitis
- ☐ M06.9 Rheumatoid Arthritis, Unspecified
- ☐ M31.6 Other Giant Cell Arteritis
- ☐ M45.9 Ankylosing Spondylitis, Unspecified
- ☐ M31.5 Giant Cell Arteritis with Polymyalgia Rheumatica
- ☐ H20.0 Iridocyclitis (Uveitis), Unspecified Acute and Subacute
- ☐ M05.9 Rheumatoid Arthritis with Rheumatoid Factor, Unspecified
- ☐ M06.00 Rheumatoid Arthritis without Rheumatoid Factor, Unspecified
- ☐ M08.00 Unspecified Juvenile Rheumatoid Arthritis of Unspecified Site
- ☐ Other: ________

**Dignosis Date**: ________ **Active TB** : Yes ☐ ☐ No **Date:** ________ **Hep B** ruled out/treated: ☐ Yes ☐ No **Date:** ________

## 4: Prescription Information

| | | Sig & Qty | Refills |
|---|---|---|---|
| **Actemra®** | ☐ Pre-filled Syringe<br>☐ Vials | ☐ **IV:** Infuse ______ mg **OR** _____ mg/kg via IV every 4 weeks (Quantity: ___)<br>☐ **SQ:** Inject 162 mg SQ every **other** week (Quantity: 2)<br>☐ **SQ:** Inject 162 mg SQ every week (Quantity: 4) | |
| **Cimzia®** | ☐ Pre-filled Syringe<br>☐ Vials | ☐ **INITIAL:** Inject 400 mg SQ at Day 0, Day 14, and Day 28 (Quantity: 6)<br>☐ **MAINTENANCE:** Inject 400 mg SQ every 4 weeks (Quantity: 2)<br>☐ **MAINTENANCE:** Inject 200 mg SQ every 2 weeks (Quantity: 2) | |
| **Enbrel®** | ☐ SureClick® Pen<br>☐ Mini™ autoTouch™<br>☐ PFS ☐ 25 mg ☐ 50 mg<br>☐ Vials 25 mg | ☐ Inject 50 mg SQ every week (Quantity: 4)<br>☐ Inject 25 mg SQ twice weekly 72-96 hours apart (Quantity: 8) | |
| **Olumiant** | ☐ 2 mg Tablets | ☐ Take 2mg PO once daily (Quantity 30) | |
| **Humira®**<br>☐ 0.8 ml<br>☐ 0.4 ml | ☐ Pen<br>☐ Pre-filled Syringe | ☐ **UVEITIS INITIAL:** Inject 80 mg SQ on Day 1, 40 mg on Day 8, then 40 mg every **other** week (Qty: 4)<br>☐ **MAINTENANCE:** Inject 40 mg SQ every **other** week (Quantity: 2)<br>☐ **MAINTENANCE:** Inject 40 mg SQ weekly (Quantity: 4) | |
| **Kevzara®** | ☐ Pre-filled Syringe<br>☐ 150 mg ☐ 200 mg | ☐ Inject 150 mg SQ every 2 weeks (Quantity: 2)<br>☐ Inject 200 mg SQ every 2 weeks (Quantity: 2) | |
| **Orencia®** | ☐ Vials<br>☐ Pre-filled Syringe<br>☐ ClickJect™ | **INTRAVENOUS (IV):**<br>☐ **INITIAL:** Infuse ______ mg via IV on week 0, 2, and 4(Quantity: ___)<br>☐ **MAINTENANCE:** Infuse ______ mg via IV every 4 weeks (Quantity: ___)<br>**SUBCUTANEOUS (SQ):**<br>☐ Inject 125mg SQ once weekly (Quantity: 4) | |
| **Simponi®** | ☐ SmartJect® (Pen)<br>☐ Pre-filled Syringe | ☐ Inject 50 mg SQ once a month (Quantity: 1) | |
| **Xeljanz®** | 5 mg Tablets | ☐ Take 5 mg PO twice daily (Quantity: 60) | |
| **Xeljanz® XR** | 11 mg Tablets | ☐ Take 11 mg PO once daily (Quantity: 30) | |
| | | | |

**Patient:** By signing this form, patient agrees to release his/her PHI to Twin Oaks Specialty Pharmacy for the purpose of medical and pharmaceutical treatment as per HIPAA compliance and to enroll in the pharmaceutical company assisted patient support programs. Patient Signature: Date:

**Prescriber Signature:** By signing this form, and utilizing our services, you are also authorizing Twin Oak Specialty Pharmacy to serve as your designated agent in dealing with medical and prescription insurance companies and co-pay assistance foundations.

Dispense as written Date Substitution Permissable Date:

**IMPORTANT NOTICE:** This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately. Pursuant to VA/OH/MO/VT law, only 1 medication is permitted per order form. Please use a new form for additional items