



Rheumatoid Arthritis (RA) Enrollment Form

1. DOCTOR/PRESCRIBER FILL OUT AND
FAX TO: 1-888-773-7386 or Call: 1-888-773-7376

- Faxes will only be accepted from a doctor's office.
- Class II medications cannot be faxed.

Patient Information New Rx Refill

Name: _____
 Address: _____
 City: _____ ST: _____ Zip: _____
 Date of Birth (mm/dd/yyyy): ____/____/____

Phone #1: _____ Phone #2: _____
 Allergies: _____ No Known Allergies
 Health Conditions: _____
 Expected Start Date: ____/____/____

Statement of Medical Necessity

Patient Weight: _____ lbs kg Primary Diagnosis: _____ ICD9 Code: _____
 ESR & Date: ____/____/____ CRP & Date: ____/____/____ # tender joints: ____ # swollen joints: ____ Morning Stiffness: ____
 History of other DMARDs: _____

Drug Delivery Information If this drug requires Prior Authorization, please send appropriate documentation (notes, test results, etc.)

- In Office Delivery Home Delivery for Self Injection/Administration
 Home Delivery for Home Health Administration

Contact: _____
 Phone #: _____
 Address: _____

Other: _____

Insurance Information Complete here or fax a copy of the patient's insurance card (both sides). Medicare card is required.

Primary: _____
 Insured: _____
 ID #: _____ Group #: _____
 Phone #: _____ Rx Drug Card #: _____
 Rx Bin #: _____ Rx PCN #: _____ Rx Grp #: _____

Secondary: _____
 Insured: _____
 ID #: _____ Group #: _____
 Phone #: _____ Rx Drug Card #: _____
 Rx Bin #: _____ Rx PCN #: _____ Rx Grp #: _____

Doctor/Prescriber Information NPI # is mandatory. DEA # is required if the prescription is for controlled substances or Medicare/Medicaid.

Name: _____
 Address: _____
 City: _____ ST: _____ Zip: _____

Office Contact: _____
 NPI #: _____ DEA #: _____
 Phone #: _____ Fax #: _____

2. COMPLETE THE FOLLOWING Rx FORM -OR- TAPE Rx HERE

Rx		Date: ____/____/____	
Drug Name/Form/Strength	Qty	Directions for Use	Refills
<input type="checkbox"/> CIMZIA® 200 mg/mL Prefilled Syringe 2 Pack <input type="checkbox"/> CIMZIA® 200 mg Vial			
<input type="checkbox"/> ENBREL® 25mg/0.5mL Prefilled Syringe <input type="checkbox"/> ENBREL® 25mg multiple-use Vial			
<input type="checkbox"/> ENBREL® 50mg/mL Prefilled Syringe <input type="checkbox"/> ENBREL® 50mg/mL SureClick™ autoinjector			
<input type="checkbox"/> HUMIRA® 40mg/0.8mL Prefilled Pen Kit			
<input type="checkbox"/> HUMIRA® 40mg/0.8mL Prefilled Syringe Kit			
<input type="checkbox"/> KINERET® 100mg Prefilled Syringe			
<input type="checkbox"/> METHOTREXATE 25 mg/mL <input type="checkbox"/> METHOTREXATE 2.5 mg Tablet			
<input type="checkbox"/> ORENCIA® 250 mg Vial (weight-based dosing)			
<input type="checkbox"/> ORENCIA® 125 mg/mL Prefilled Syringe			
<input type="checkbox"/> REMICADE® 100mg Vial (weight based dosing)			
<input type="checkbox"/> RITUXAN® <input type="checkbox"/> 100mg/10mL Vial <input type="checkbox"/> 500mg/50mL Vial			
<input type="checkbox"/> SIMPONI™ 50mg/0.5mL SmartJect autoinjector			
<input type="checkbox"/> SIMPONI™ 50mg/0.5mL Prefilled Syringe			
Other:			
Needles Gauge: ____ Inches: ____ Quantity: ____ Refills: ____		Syringes Volume: ____ Inches: ____ Quantity: ____ Refills: ____	
X _____ Doctor/Prescriber Signature – Dispense as Written Stamped signatures cannot be accepted		X _____ Doctor/Prescriber Signature – Substitution Permissible Stamped signatures cannot be accepted	

Federally approved, generic-equivalent medications will be dispensed for brand-name medications unless otherwise directed by the patient, physician, or health plan.
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