BLUEGRASS PHARMACY | RHEUMATOLOGY ENROLLMENT FORM

BLUEGRASS Pharmacy
A Member of the Wellpartner Family

FAX FORM TO: 1.866.233.8317 | **PHONE:** 1.855.492.0817 | **EMAIL:** contact@bluegrass-rx.com

Complete the following or include demographic sheet.

1. PATIENT INFORMATION

Name:
Address:
City, State, ZIP:
Primary Phone: - - DOB: / /
Alternate Phone: - - Gender:
Email:
Primary Language: Last Four of SSN:

2. PRESCRIBER INFORMATION

Name:
DEA #: NPI #: State Lic. #:
Group or Hospital:
Address:
City, State, Zip:
Phone: - - Fax: - -
Contact Person: Phone: - -

3. INSURANCE INFORMATION

*Fax copy of **prescription** and **insurance cards** with this form, if available (front and back)*

Primary Insurance Company Name:
Primary Cardholder Name:
Relationship: ◯ Self ◯ Spouse/Partner ◯ Child/Dependent
Phone: - - Member ID: Group #:

Secondary Insurance Company Name:
Secondary Cardholder Name:
Relationship: ◯ Self ◯ Spouse/Partner ◯ Child/Dependent
Phone: - - Member ID: Group #:

4. DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: / /

◯ MØ6.9 Rheumatoid arthritis, unspecified
◯ MØ8.9 Juvenile arthritis, unspecified
◯ M45.9 Ankylosing spondylitis
◯ L4Ø.5 Arthropathic psoriasis
◯ Other:

Prior (failed medications)

Medication	Duration of Tx/Reason for d/c

Has patient received injection training? ◯ Yes ◯ No

Ship to: ◯ Patient ◯ Office ◯ Other:

Height (in/cm): Weight (lb/kg): ESR & date: / / CRP & date: / /

Has patient had TB test? ◯ Yes ◯ No If yes, results:

Has patient tried and failed 8-12 weeks of oral systemic DMARD agent? ◯ Yes ◯ No

Are there any contraindications to any arthritis agents? ◯ Yes ◯ No
If yes, drug(s): Reason(s):

Please check if patient has any of the following: ◯ Liver failure ◯ Lymphoma ◯ Serious/active infection

Is patient at risk for hepatitis B infection? ◯ Yes ◯ No
If yes, has hepatitis B been ruled out or treatment initiated? ◯ Yes ◯ No

Concomitant Medications: ◯ Methotrexate ◯ Other:

Allergies:

5. PRESCRIPTION INFORMATION

Medication	Dose/Strength	Directions	Quantity	Refills
◯ Actemra™	◯ 162 mg/0.9 ml prefilled syringe	◯ Patients < 100 kg: Inject 162 mg SQ every other week, followed by an increase to every week based on clinical response ◯ Patients ≥ 100 kg: Inject 162 mg SQ every week		
◯ Cimzia™	◯ Starter kit	◯ Inject 400 mg SQ on day 1, at week 2, and at week 4	1 kit (6 vials)	0
	◯ 200 mg/1 ml prefilled syringe ◯ 200 mg vial	◯ Inject 200 mg SQ every other week ◯ Inject 400 mg SQ every 4 weeks ◯ Other:		
◯ Enbrel™	◯ 25 mg/0.5 ml PFS ◯ 25 mg vial ◯ 50 mg/ml prefilled syringe (PFS) ◯ 50 mg/ml Sureclick Autoinjector	◯ Inject 50 mg SQ once a week ◯ Inject 25 mg SQ twice a week (72-96 hours apart) ◯ Other:		
◯ Humira™	◯ Pen ◯ 20 mg/0.4 ml ◯ Prefilled syringe ◯ 40 mg/0.8 ml	◯ Inject 20 mg SQ every other week ◯ Inject 40 mg SQ every other week ◯ Other:		
◯ Kineret™	◯ 100 mg prefilled syringe	◯ Inject 100 mg (one syringe) SQ once a day		
◯ Orencia	◯ 250 mg vial ◯ 125 mg subcutaneous	◯ Infuse _____ mg in 100ml 0.9% NaCl at weeks 0, 2, and 4, then every 4 weeks ◯ Other:		
◯ Remicade™	◯ 100 mg vial ◯ _____ mg/kg	◯ IV in 250ml 0.9% NaCl at 0, 2, and 6 weeks. ◯ IV in 250ml 0.9% NaCl at every _____ weeks		
◯ Rituxan™	◯ 100 mg/10 ml vial ◯ 500 mg/50 ml vial	◯ Infuse two doses of 1000mg in 1 liter 0.9% NaCl two weeks apart. ◯ Other:		
◯ Simponi™	◯ 50 mg/0.5 ml SmartJect Autoinjector ◯ 50 mg/0.5 ml prefilled syringe	◯ Inject 50 mg (0.5 ml) SQ once a month ◯ Other:		
◯ Simponi™ ARIA	◯ 50 mg/4 ml (12.5 mg/ml) in a single use vial			
◯ Stelara™	◯ 45 mg/0.5 ml in a single-use PFS ◯ 90 mg/ml in a single-use prefilled syringe (PFS)	◯ Inject 45 mg SQ initially and 4 weeks later, then 45 mg SQ every 12 weeks ◯ For patients > 100 kg with co-existent moderate to severe plaque psoriasis, 90 mg initially and 4 weeks later, followed by 90 mg every 12 weeks		
◯				

Ancillary supplies and kits will be provided as needed for administration.

6. PRESCRIBER SIGNATURE

X / /
DISPENSE AS WRITTEN DATE

X / /
PRODUCT SUBSTITUTION PERMITTED DATE