PHARMACA
SPECIALTY PHARMACY

RHEUMATOID ARTHRITIS ENROLLMENT FORM

Fax: **888-882-3341**
Call 24/7: **855-465-8892**

1 PATIENT INFORMATION:

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Alt Phone: _____
Email: _____
DOB: _____ ☐ M ☐ F Last 4 of SSN: _____

2 PRESCRIBER INFORMATION:

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____
NPI: _____ DEA: _____
Office Contact: _____ Phone: _____

3 INSURANCE INFORMATION:

Please attach front and back copies of prescription/medical insurance card(s).

4 CLINICAL INFORMATION:

To expedite prior authorization, please attach relevant clinical documentation.

Primary ICD-10: _____ Drug Allergies: ☐ NKDA ☐ _____

If prior authorization is denied, preferred alternatives or the option to appeal, if available, will be provided to the office.

Additional Information: _____

5 INJECTION TRAINING:

☐ Physician to Train ☐ Pharmacist to Train ☐ Other: _____

6 PRODUCT DELIVERY:

☐ Physician's Office ☐ Patient's Home ☐ Other: _____

PRESCRIPTION INFORMATION:

Medication	Dose/Strength	Directions	Qty	Refills
☐ **Actemra®**	☐ 200mg/ml Prefilled Syringe	☐ Inject 162mg SC every week (> 220lbs) ☐ Inject 162mg SC every other week ☐ Inject 162mg SC every 3 weeks (< 66lbs)		
☐ **Cimzia®**	☐ Prefilled Syringe Starter Kit ☐ 200mg/ml Prefilled Syringe ☐ 200mg Lyophilized Powder Vial	☐ **Induction:** Inject 400mg SC on day 1, day 14 and day 28	6	0
		☐ **Maintenance:** Inject 400mg SC every 4 weeks ☐ **Maintenance:** Inject 200mg SC every other week	2	
☐ **Colcigel®**	☐	☐		
☐ **Cosentyx®**	☐ 150mg/ml Sensoready® Pen ☐ 150mg/ml Prefilled Syringe ☐ 150mg Lyophilized Powder Vial	☐ **Induction:** Inject 150mg SC at weeks 0, 1, 2, 3, and 4	5	0
		☐ **Induction:** Inject 300mg SC at weeks 0, 1, 2, 3, and 4	10	0
		☐ **Maintenance:** Inject 150mg SC every four weeks	1	
		☐ **Maintenance:** Inject 300mg SC every four weeks	2	
☐ **Enbrel®**	☐ 50mg/ml SureClick® Autoinjector ☐ 50mg/ml Enbrel Mini™ Prefilled Cartridge for use with the AutoTouch™ Autoinjector ☐ 50mg/ml Prefilled Syringe ☐ 25mg/ml Prefilled Syringe ☐ 25mg Lyophilized Powder Multi-Dose Vial	☐ Inject 50mg SC once weekly ☐ Inject 25mg SC twice weekly (3-4 days apart) ☐ **Other:** _____		
☐ **Humira®**	☐ 40mg/0.8ml Pen ☐ 40mg/0.4ml Pen Citrate-free ☐ 40mg/0.8ml Syringe ☐ 40mg/0.4ml Syringe Citrate-free	☐ Inject 40mg SC every other week ☐ Inject 40mg SC every week		
☐ **Kevzara®**	☐ 125mg/ml ClickJect™ Autoinjector ☐ 125mg/ml Prefilled Syringe	☐ Inject 125mg SC once weekly	4	
☐ **Orencia®**	☐ 125mg/ml ClickJect® Autoinjector ☐ 125mg/ml Prefilled Syringe ☐ 50mg/0.4ml Prefilled Syringe ☐ 87.5mg/0.7ml Prefilled Syringe ☐ 250mg Lyophilized Powder Vial	☐ **Induction:** Administer _____mg IV, then inject 125mg SC within 24 hours		0
		☐ Inject 50mg SC once weekly (10-25kg) ☐ Inject 87.5mg SC once weekly (25-50kg) ☐ Inject 125mg SC once weekly (> 50kg)	4	
☐ **Otezla®**	☐ Starter Pack ☐ 30mg Tablets	☐ **Initial Titration:** Take one tablet in the morning on day 1, then take one tablet in the morning and one tablet in the evening as directed on the starter pack	1	0
		☐ **Maintenance:** Take one 30mg tablet by mouth twice daily	60	
☐ **Rasuvo®**	☐	☐		
☐ **Simponi®**	☐ 50mg/0.5ml SmartJect® Autoinjector ☐ 50mg/05.ml Prefilled Syringe	☐ Inject 50mg SC once monthly	1	
☐ **Stelara®**	☐ 45mg/0.5ml Prefilled Syringe (< 100kg) ☐ 90mg/ml Prefilled Syringe (> 100kg)	☐ **Induction:** Inject the contents of 1 prefilled syringe SC on day 1	1	0
		☐ **Maintenance:** Inject the contents of 1 prefilled syringe SC on day 29 and every 12 weeks thereafter	1	
☐ **Xeljanz®**	☐ 5mg Tablets	☐ Take one 5mg tablet by mouth twice daily	60	
☐ **Xeljanz® XR**	☐ 11mg Tablets	☐ Take one 11mg tablet by mouth once daily	30	
☐	☐	☐		

I authorize Pharmaca and its affiliates to act on my behalf to obtain prior authorization and/or other assistance if applicable. I acknowledge that prior authorization/payment is not guaranteed.

X PHYSICIAN SIGNATURE REQUIRED X

Substitution Permitted Date Dispense as Written Date