PHARMACA
SPECIALTY PHARMACY

RHEUMATOID ARTHRITIS ENROLLMENT FORM

Fax: **888.882.3341**
Call: **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 and Form	Directions	Qty	Refills
☐ **Actemra**	☐ 200 mg/mL Prefilled Syringe	☐ Inject 162 mg SC every week (> 220lbs) ☐ Inject 162 mg SC every other week ☐ Inject 162 mg SC every 3 weeks (< 66lbs)		
☐ **Cimzia**	☐ Prefilled Syringe Starter Kit ☐ 200 mg/mL Prefilled Syringe ☐ 200 mg Lyophilized Powder Vial	☐ **Induction:** Inject 400 mg SC on day 1, day 14 and day 28	6	0
		☐ **Maintenance:** Inject 400 mg SC every 4 weeks ☐ **Maintenance:** Inject 200 mg SC every other week	2	
☐ **Colcigel**	☐	☐		
☐ **Cosentyx**	☐ 150 mg/mL Sensoready Pen ☐ 150 mg/mL Prefilled Syringe ☐ 150 mg Lyophilized Powder Vial	☐ **Induction:** Inject 150 mg SC at weeks 0, 1, 2, 3, and 4	5	0
		☐ **Induction:** Inject 300 mg SC at weeks 0, 1, 2, 3, and 4	10	0
		☐ **Maintenance:** Inject 150 mg SC every four weeks	1	
		☐ **Maintenance:** Inject 300 mg SC every four weeks	2	
☐ **Enbrel**	☐ 50 mg/mL SureClick Autoinjector ☐ 50 mg/mL Enbrel Mini Prefilled Cartridge for use with the AutoTouch Autoinjector ☐ 50 mg/mL Prefilled Syringe ☐ 25 mg/mL Prefilled Syringe ☐ 25 mg Lyophilized Powder Multi-Dose Vial	☐ Inject 50 mg SC once weekly ☐ Inject 25 mg SC twice weekly (3-4 days apart) ☐ **Other:** _____		
☐ **Humira**	☐ 40 mg/0.4 mL Pen Citrate-free ☐ 40 mg/0.4 mL Prefilled Syringe Citrate-free	☐ Inject 40 mg SC every other week ☐ Inject 40 mg SC every week		
☐ **Kevzara**	☐ 125 mg/mL ClickJect Autoinjector ☐ 125 mg/mL Prefilled Syringe	☐ Inject 125 mg SC once weekly	4	
☐ **Olumiant**	☐ 1 mg Tablets ☐ 2 mg Tablets	☐ Take one tablet by mouth once daily		
☐ **Orencia**	☐ 125 mg/mL ClickJect Autoinjector ☐ 125 mg/mL Prefilled Syringe ☐ 50 mg/0.4 mL Prefilled Syringe ☐ 87.5 mg/0.7 mL Prefilled Syringe ☐ 250 mg Lyophilized Powder Vial	☐ **Induction:** Administer _____ mg IV, then inject 125 mg SC within 24 hours		0
		☐ Inject 50 mg SC once weekly (10-25 kg) ☐ Inject 87.5 mg SC once weekly (25-50 kg) ☐ Inject 125 mg SC once weekly (> 50 kg)	4	
☐ **Otezla**	☐ Starter Pack ☐ 30 mg 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 30 mg tablet by mouth twice daily	60	
☐ **Rasuvo**	☐	☐		
☐ **Simponi**	☐ 50 mg/0.5 mL SmartJect Autoinjector ☐ 50 mg/0.5 mL Prefilled Syringe	☐ Inject 50 mg SC once monthly	1	
☐ **Stelara**	☐ 45 mg/0.5 mL Prefilled Syringe (< 100 kg) ☐ 90 mg/mL Prefilled Syringe (> 100 kg)	☐ **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	
☐ **Taltz**	☐ 80 mg/mL Autoinjector ☐ 80 mg/mL Prefilled Syringe	☐ **Induction:** Inject 160 mg SC at week 0	2	0
		☐ **Maintenance:** Inject 80 mg SC every 4 weeks thereafter	1	
☐ **Xeljanz**	☐ 5 mg Tablets	☐ Take one 5 mg tablet by mouth twice daily	60	
☐ **Xeljanz XR**	☐ 11 mg Tablets	☐ Take one 11 mg 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