



**Rheumatology  
Enrollment Form  
A - H**

Physician Offices Call:  
855-460-7928

Fax: 888-777-5645

<b>Prescribing Practitioner:</b>		<b>NPI:</b>
<b>Supervising Physician:</b>		<b>NPI:</b>
Address:		<b>Tax ID:</b>
Office:	Fax:	
Contact:		

This prescription form is to be sent & received via fax

PATIENT INFORMATION					
Name:	<input type="checkbox"/> M <input type="checkbox"/> F	DOB: ____/____/____	SS#: ____-____-____		
Street:	City:	State:	ZIP:		
Tel:	Alt. Tel:	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____	Wt.: _____	Ht.: _____	

PRESCRIPTION			
<input type="checkbox"/> New <input type="checkbox"/> Refill	Ship by: ____/____/____	SHIP TO: <input type="checkbox"/> Patient's Home <input type="checkbox"/> Doctor's Office <input type="checkbox"/> Other: _____	
Drug	Directions & Quantity	Refills	
<b>Actemra®</b> <input type="checkbox"/> Pre-filled Syringe <input type="checkbox"/> Vials	<input type="checkbox"/> IV: Infuse _____ mg OR _____ mg/kg via IV every 4 weeks (Quantity: ____) <input type="checkbox"/> SQ: Inject 162 mg SQ every <b>other</b> week (Quantity: 2) <input type="checkbox"/> SQ: Inject 162 mg SQ every week (Quantity: 4)		
<b>Cimzia®</b> <input type="checkbox"/> Pre-filled Syringe <input type="checkbox"/> Vials	<input type="checkbox"/> INITIAL: Inject 400 mg SQ at Day 0, Day 14, and Day 28 (Quantity: 6) <input type="checkbox"/> MAINTENANCE: Inject 400 mg SQ every 4 weeks (Quantity: 2) <input type="checkbox"/> MAINTENANCE: Inject 200 mg SQ every 2 weeks (Quantity: 2)		
<b>Cosentyx™</b> <input type="checkbox"/> Sensoready Pen <input type="checkbox"/> Pre-filled Syringe	<input type="checkbox"/> INITIAL: Inject 150 mg SQ on week 0, 1, 2, 3, and 4 (Quantity: 5) <input type="checkbox"/> MAINTENANCE: Inject 150 mg SQ every 4 weeks (Quantity: 1) <input type="checkbox"/> INITIAL: Inject 300 mg SQ on week 0, 1, 2, 3, and 4 (Quantity: 10) <input type="checkbox"/> MAINTENANCE: Inject 300 mg SQ every 4 weeks (Quantity: 2)		
<b>Cosentyx™ Covered Until You're Covered</b> <input type="checkbox"/> Sensoready Pen <input type="checkbox"/> Pre-filled Syringe	<input type="checkbox"/> INITIAL: Inject 150 mg SQ on week 0, 1, 2, 3, and 4 (Quantity: 5) <input type="checkbox"/> MAINTENANCE: Inject 150 mg SQ every 4 weeks (Quantity: 1) <input type="checkbox"/> INITIAL: Inject 300 mg SQ on week 0, 1, 2, 3, and 4 (Quantity: 10) <input type="checkbox"/> MAINTENANCE: Inject 300 mg SQ every 4 weeks (Quantity: 2)		
<b>Enbrel®</b> <input type="checkbox"/> SureClick® Pen <input type="checkbox"/> Mini™ with AutoTouch™ <input type="checkbox"/> Pre-filled Syringe <input type="checkbox"/> 25 mg <input type="checkbox"/> 50 mg <input type="checkbox"/> Vials 25 mg	<input type="checkbox"/> Inject 50 mg SQ every week (Quantity: 4) <input type="checkbox"/> Inject 25 mg SQ twice weekly 72-96 hours apart (Quantity: 8)		
<b>Humira® Citrate Free</b> <input type="checkbox"/> Uveitis Starter Kit <input type="checkbox"/> Pen <input type="checkbox"/> Pre-filled Syringe	<input type="checkbox"/> UVEITIS INITIAL: Inject 80 mg SQ on Day 1, 40 mg on Day 8, then 40 mg every <b>other</b> week (Quantity: 3) <input type="checkbox"/> MAINTENANCE: Inject 40 mg SQ every <b>other</b> week (Quantity: 2) <input type="checkbox"/> MAINTENANCE: Inject 40 mg SQ weekly (Quantity: 4)		
<b>Humira®</b> <input type="checkbox"/> Uveitis Starter Kit <input type="checkbox"/> Pen <input type="checkbox"/> Pre-filled Syringe	<input type="checkbox"/> UVEITIS INITIAL: Inject 80 mg SQ on Day 1, 40 mg on Day 8, then 40 mg every <b>other</b> week (Quantity: 4) <input type="checkbox"/> MAINTENANCE: Inject 40 mg SQ every <b>other</b> week (Quantity: 2) <input type="checkbox"/> MAINTENANCE: Inject 40 mg SQ weekly (Quantity: 4)		

**MEDICAL INFORMATION**  
\*\*\*PLEASE FAX COPY OF PRESCRIPTION/MEDICAL CARD, FRONT AND BACK, AS WELL AS ANY CLINICAL NOTES REGARDING THERAPY\*\*\*

PREVIOUS THERAPIES:	Tried & Failed (Duration):	Not Tolerated:	Contraindication:
<input type="checkbox"/> Methotrexate	<input type="checkbox"/> (____)	<input type="checkbox"/>	_____
<input type="checkbox"/> Plaquenil	<input type="checkbox"/> (____)	<input type="checkbox"/>	_____
<input type="checkbox"/> Meloxicam	<input type="checkbox"/> (____)	<input type="checkbox"/>	_____
<input type="checkbox"/> Naproxen / Aleve	<input type="checkbox"/> (____)	<input type="checkbox"/>	_____
<input type="checkbox"/> Tramadol	<input type="checkbox"/> (____)	<input type="checkbox"/>	_____
<input type="checkbox"/> Enbrel	<input type="checkbox"/> (____)	<input type="checkbox"/>	_____
<input type="checkbox"/> Humira	<input type="checkbox"/> (____)	<input type="checkbox"/>	_____
<input type="checkbox"/> Cimzia	<input type="checkbox"/> (____)	<input type="checkbox"/>	_____
<input type="checkbox"/> _____	<input type="checkbox"/> (____)	<input type="checkbox"/>	_____
<input type="checkbox"/> _____	<input type="checkbox"/> (____)	<input type="checkbox"/>	_____

<input type="checkbox"/> H20.9 Unspecified Iridocyclitis	<input type="checkbox"/> H20.0 Iridocyclitis (Uveitis), Unspecified Acute and Subacute
<input type="checkbox"/> M06.9 Rheumatoid Arthritis, Unspecified	<input type="checkbox"/> M05.9 Rheumatoid Arthritis with Rheumatoid Factor, Unspecified
<input type="checkbox"/> M31.6 Other Giant Cell Arteritis	<input type="checkbox"/> M06.00 Rheumatoid Arthritis without Rheumatoid Factor, Unspecified
<input type="checkbox"/> M45.9 Ankylosing Spondylitis, Unspecified	<input type="checkbox"/> M08.00 Unspecified Juvenile Rheumatoid Arthritis of Unspecified Site
<input type="checkbox"/> M31.5 Giant Cell Arteritis with Polymyalgia Rheumatica	<input type="checkbox"/> Other: _____

Date of Diagnosis: \_\_\_\_/\_\_\_\_/\_\_\_\_ Allergies: \_\_\_\_\_

Active TB is ruled out:  Yes  No Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Hep B ruled out/treated:  Yes  No Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Additional Clinical Information: \_\_\_\_\_

**INJECTION TRAINING**  
 Patient has received pen and injection training  Physician's office to provide injection training  Senderra to coordinate injection training

**PRESCRIBING PRACTITIONER SIGNATURE**  
To Prescribing Practitioner: By signing this form and utilizing our services, you are also authorizing Senderra to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies, and co-pay assistance foundations.

Prescribing Practitioner: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**CONFIDENTIALITY NOTICE**  
IMPORTANT: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, proprietary or exempt from disclosure under applicable law. If you are not the named addressee, you should 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.