

# Rheumatology enrollment form

Phone: 855-425-4085 Fax: 855-425-4096 ardonhealth.com



Date needed	Medication start date	Ship to: <input type="checkbox"/> Patient <input type="checkbox"/> Physician <input type="checkbox"/> Other:
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Patient information					
Patient name	Date of birth	Phone	Alternate phone		
Address	City	State	ZIP		
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Email	Primary language	Height	Weight	

Prescriber information					
Prescriber name	State License #	NPI #	DEA #		
Group or hospital	Address	City	State	ZIP	
Phone	Fax	Contact person name and phone			

**Insurance information:** If available, please fax a copy of the prescription and insurance card(s) with this form (front and back).

Clinical	
Date of diagnosis	Diagnosis: <input type="checkbox"/> M06.9 Rheumatoid Arthritis <input type="checkbox"/> M08.9 Juvenile Arthritis <input type="checkbox"/> L40.54 Psoriatic Arthritis <input type="checkbox"/> M45.9 Ankylosing Spondylitis <input type="checkbox"/> M46.80 Non-radiographic Axial Spondyloarthritis <input type="checkbox"/> New diagnosis <input type="checkbox"/> Other _____
Previous medications: <input type="checkbox"/> Acetaminophen, ibuprofen, naproxen, aspirin <input type="checkbox"/> Humira <input type="checkbox"/> Enbrel <input type="checkbox"/> Methotrexate <input type="checkbox"/> Corticosteroids <input type="checkbox"/> Hydroxychloroquine <input type="checkbox"/> Leflunomid <input type="checkbox"/> Sulfasalazine <input type="checkbox"/> Other meds tried: _____	Current medications:  Allergies:  Has patient had positive TB test? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, date of last chest x-ray _____</i> Is the patient also taking methotrexate? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the patient new to therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No Is a starter dose needed? <input type="checkbox"/> Yes <input type="checkbox"/> No

Prescription information				
Medication	Dose/strength	Directions	Quantity	Refill
<input type="checkbox"/> Actemra®	<input type="checkbox"/> 162 mg/0.9 mL Pen	<input type="checkbox"/> Inject 162 mg SUBQ every 14 days	<input type="checkbox"/> 2 Pens/PFS	
	<input type="checkbox"/> 162 mg/0.9 mL Prefilled Syringe	<input type="checkbox"/> Inject 162 mg SUBQ every 7 days	<input type="checkbox"/> 4 Pens/PFS	
<input type="checkbox"/> Benlysta®	<input type="checkbox"/> 200 mg/mL Pen	<input type="checkbox"/> Starter Dose (Lupus Nephritis): Inject 400 mg SUBQ every 7 days for 4 doses, then 200 mg every 7 days thereafter	<input type="checkbox"/> 8 Pens/PFS	0
	<input type="checkbox"/> 200 mg/mL Prefilled Syringe	<input type="checkbox"/> Maintenance Dose: Inject 200 mg SUBQ every 7 days.	<input type="checkbox"/> 4 Pens/PFS	
<input type="checkbox"/> Cimzia®	<input type="checkbox"/> Starter Kit (200 mg/mL Prefilled Syringes)	<input type="checkbox"/> Inject 400 mg SUBQ at weeks 0, 2, and 4	0 1 Kit = 6 x 200 mg/mL PFS	0
	<input type="checkbox"/> 200 mg/mL Prefilled Syringe	<input type="checkbox"/> Inject 400 mg SUBQ every 28 days	<input type="checkbox"/> 2 PFS	
	<input type="checkbox"/> 200 mg Vial	<input type="checkbox"/> Inject 200 mg SUBQ every 14 days <input type="checkbox"/> Other: _____	<input type="checkbox"/> 2 Vials	

Physician signature required	
<b>Product substitution permitted</b> <input checked="" type="checkbox"/> _____ Date _____	<b>Dispense as written</b> <input checked="" type="checkbox"/> _____ Date _____

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

The information included in this FAX is intended for the sole use of the individual to whom it is addressed and may contain information that is privileged, confidential and exempt from disclosure under applicable law. If you are not the intended addressee, nor authorized to receive for the intended addressee, you are hereby notified that you may not use, copy, disclose or distribute this information. If you have received this FAX in error, please contact the sender and destroy the entire document.

<input type="checkbox"/> Cosentyx®	<input type="checkbox"/> 300 mg/2 mL Pen	<input type="checkbox"/> Starter Dose: Inject 300 mg SUBQ day 1, day 8, day 15, day 22, and then every 28 days starting on day 29	<input type="checkbox"/> 4 Pens	0
		<input type="checkbox"/> Maintenance Dose: Inject 300 mg SUBQ on day 29, then every 28 days thereafter	<input type="checkbox"/> 1 Pen	
	<input type="checkbox"/> 150 mg/mL Pen <input type="checkbox"/> 150 mg/mL Prefilled Syringe	<input type="checkbox"/> Starter Dose: Inject 300 mg SUBQ day 1, day 8, day 15, day 22, and then every 28 days starting on day 29	<input type="checkbox"/> 8 Pens/PFS	0
		<input type="checkbox"/> Starter dose: Inject 150 mg SUBQ day 1, day 8, day 15, day 22, and then every 28 days starting on day 29	<input type="checkbox"/> 4 Pens/PFS	0
		<input type="checkbox"/> Maintenance Dose: Inject 300 mg SUBQ on day 29, then every 28 days thereafter	<input type="checkbox"/> 2 Pens/PFS	
	<input type="checkbox"/> 75 mg/0.5 mL Prefilled Syringe (pediatric)	<input type="checkbox"/> Maintenance Dose: Inject 150 mg SUBQ on day 29, then every 28 days thereafter	<input type="checkbox"/> 2 Pens/PFS	
<input type="checkbox"/> Starter Dose (pediatric, 15 to < 50 kg): Inject 75 mg SUBQ day 1, day 8, day 15, and day 22 and then every 28 days starting on day 29		<input type="checkbox"/> 4 PFS	0	
	<input type="checkbox"/> Maintenance Dose (pediatric, 15 to < 50 kg): Inject 75 mg SUBQ on day 29, then every 28 days thereafter	<input type="checkbox"/> 1 PFS		
<input type="checkbox"/> Enbrel®	<input type="checkbox"/> 50 mg/mL Pen <input type="checkbox"/> 50 mg/mL Prefilled Syringe <input type="checkbox"/> 50 mg/mL Mini Cartridge <input type="checkbox"/> 25 mg/0.5 mL Prefilled Syringe <input type="checkbox"/> 25 mg/0.5 mL Single-dose Vial	<input type="checkbox"/> Inject 50 mg SUBQ every 7 days <input type="checkbox"/> Inject 25 mg SUBQ 2 times weekly (72-96 hours apart) <input type="checkbox"/> Other: _____	<input type="checkbox"/> 4 <input type="checkbox"/> 8	
<input type="checkbox"/> Humira®	<input type="checkbox"/> 40 mg/0.8 mL Pen <input type="checkbox"/> 40 mg/0.8 mL Prefilled Syringe <input type="checkbox"/> 20 mg/0.4 mL Prefilled Syringe <input type="checkbox"/> 10 mg/0.2 mL Prefilled Syringe	<input type="checkbox"/> Inject 40 mg SUBQ every 14 days <input type="checkbox"/> Inject 40 mg SUBQ every 7 days <input type="checkbox"/> Other: _____	<input type="checkbox"/> 2 Pens/PFS <input type="checkbox"/> 4 Pens/PFS	
<input type="checkbox"/> Humira® (Citrate-free)	<input type="checkbox"/> 80 mg/0.8 mL CF Pen <input type="checkbox"/> 40 mg/0.4 mL CF Pen <input type="checkbox"/> 40 mg/0.4 mL CF Prefilled Syringe <input type="checkbox"/> 20 mg/0.2 mL CF Prefilled Syringe <input type="checkbox"/> 10 mg/0.1 mL CF Prefilled Syringe	<input type="checkbox"/> Inject 40 mg SUBQ every 14 days <input type="checkbox"/> Inject 80 mg SUBQ every 14 days <input type="checkbox"/> Inject 40 mg SUBQ every 7 days <input type="checkbox"/> Other: _____	<input type="checkbox"/> 2 Pens/PFS <input type="checkbox"/> 4 Pens/PFS	
<input type="checkbox"/> Kevzara®	<input type="checkbox"/> 150 mg/1.14 mL Pen <input type="checkbox"/> 200 mg/1.14 mL Pen <input type="checkbox"/> 150 mg/1.14 mL Prefilled Syringe <input type="checkbox"/> 200 mg/1.14 mL Prefilled Syringe	<input type="checkbox"/> Inject 150 mg SUBQ every 14 days <input type="checkbox"/> Inject 200 mg SUBQ every 14 days	<input type="checkbox"/> 2 Pens/PFS	
<input type="checkbox"/> Olumiant®	<input type="checkbox"/> 1 mg Tablet <input type="checkbox"/> 2 mg Tablet	<input type="checkbox"/> Take 1 tablet by mouth once daily	<input type="checkbox"/> 30 Tablets	
<input type="checkbox"/> Orencia®	<input type="checkbox"/> 250 mg Vial (IV use only)	<input type="checkbox"/> _____ mg IV x 1 dose, then 125 mg SUBQ every 7 days, start within 24 hours of IV dose <input type="checkbox"/> Other: _____	<input type="checkbox"/> 1 Vial	
	<input type="checkbox"/> 125 mg/mL Pen <input type="checkbox"/> 125 mg/mL Prefilled Syringe	<input type="checkbox"/> Inject 125 mg SUBQ every 7 days	<input type="checkbox"/> 4 Pens/PFS	
	<input type="checkbox"/> 87.5 mg/0.7 mL Prefilled Syringe	<input type="checkbox"/> Inject 87.5 mg SUBQ every 7 days <input type="checkbox"/> Other: _____	<input type="checkbox"/> 4 PFS	
	<input type="checkbox"/> 50 mg/0.4 mL Prefilled Syringe	<input type="checkbox"/> Inject 50 mg SUBQ every 7 days <input type="checkbox"/> Other: _____	<input type="checkbox"/> 4 PFS	
<input type="checkbox"/> Otezla®	<input type="checkbox"/> Starter Kit	<input type="checkbox"/> Starter Dose: Take as directed per package instructions	<input type="checkbox"/> 1 Starter Kit (55 Tablets)	0
	<input type="checkbox"/> 30 mg Tablet	<input type="checkbox"/> Maintenance Dose: Take 1 tablet by mouth 2 times daily <input type="checkbox"/> Other: _____	<input type="checkbox"/> 60 Tablets _____ Tablets	
<input type="checkbox"/> Remicade®	<input type="checkbox"/> 100 mg Vial	<input type="checkbox"/> Induction: Infuse _____ mg IV at weeks 0, 2, and 6 <input type="checkbox"/> Maintenance Dose: Infuse _____ mg IV every 8 weeks	_____ Vial(s) _____ Vial(s)	0
<input type="checkbox"/> Rinvoq®	<input type="checkbox"/> 15 mg XR Tablet	<input type="checkbox"/> Take 1 tablet by mouth once daily	<input type="checkbox"/> 30 Tablets	

**Physician signature required**

**Product substitution permitted**

X \_\_\_\_\_ Date \_\_\_\_\_

**Dispense as written**

X \_\_\_\_\_ Date \_\_\_\_\_

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<input type="checkbox"/> Simponi®	<input type="checkbox"/> 50 mg/0.5 mL Pen <input type="checkbox"/> 50 mg/0.5 mL Prefilled Syringe <input type="checkbox"/> 100 mg/mL Pen <input type="checkbox"/> 100 mg/mL Prefilled Syringe	<input type="checkbox"/> Inject 1 dose SUBQ once a month <input type="checkbox"/> Other: _____	<input type="checkbox"/> 1 Pen/PFS	
<input type="checkbox"/> Skyrizi®	<input type="checkbox"/> 150 mg/mL Pen <input type="checkbox"/> 150 mg/mL Prefilled Syringe	<input type="checkbox"/> Starter Dose: Inject 150 mg SUBQ at week 0 and 4, followed by every 12 weeks thereafter <input type="checkbox"/> Maintenance Dose: Inject 150 mg SUBQ at week 4, then every 12 weeks	<input type="checkbox"/> 1 Pen/PFS	0
<input type="checkbox"/> Stelara®	<input type="checkbox"/> 45 mg/0.5 mL Prefilled Syringe <input type="checkbox"/> 45 mg/0.5 mL Single-dose Vial <input type="checkbox"/> 90 mg/mL Prefilled Syringe	<input type="checkbox"/> Starter Dose: Inject 1 prefilled syringe SUBQ at weeks 0 and 4, and then every 12 weeks thereafter	<input type="checkbox"/> 1 PFS	0
		<input type="checkbox"/> Maintenance Dose: Inject 1 prefilled syringe SUBQ at week 4, then every 12 weeks thereafter	<input type="checkbox"/> 1 PFS	
		<input type="checkbox"/> Other: _____		
<input type="checkbox"/> Taltz®	<input type="checkbox"/> 80 mg/mL Autoinjector <input type="checkbox"/> 80 mg/mL Prefilled Syringe	<input type="checkbox"/> Starter Dose: Inject 160 mg SUBQ day 1, followed by 80 mg every 28 days starting on day 29	<input type="checkbox"/> 2 Pens/PFS	0
		<input type="checkbox"/> Maintenance Dose: Inject 80 mg SUBQ on day 29, then every 28 days thereafter	<input type="checkbox"/> 1 Pen/PFS	
<input type="checkbox"/> Tremfya®	<input type="checkbox"/> 100 mg/mL Pen <input type="checkbox"/> 100 mg/mL Prefilled Syringe	<input type="checkbox"/> Starter Dose: Inject 100 mg SUBQ at weeks 0 and 4, then every 8 weeks thereafter	<input type="checkbox"/> 1 Pen/PFS	0
		<input type="checkbox"/> Maintenance Dose: Inject 100 mg SUBQ at week 4, then every 8 weeks thereafter	<input type="checkbox"/> 1 Pen/PFS	
<input type="checkbox"/> Xeljanz®	<input type="checkbox"/> 5 mg Tablet <input type="checkbox"/> 11 mg XR Tablet <input type="checkbox"/> 1 mg/mL Oral Solution	<input type="checkbox"/> Take 1 tablet by mouth 2 times daily <input type="checkbox"/> Take 1 tablet by mouth once daily <input type="checkbox"/> Other: _____	<input type="checkbox"/> 60 Tablets <input type="checkbox"/> 30 Tablets <input type="checkbox"/> 240 mL Bottle	

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