ardon

Rheumatology Enrollment Form

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

PATIENT INFORMATION

Patient Name:
Address:
City: State: Zip:
Primary Phone: DOB:
Alternate Phone: Gender: ☐ Male ☐ Female
Email:
Last Four of SS #: Primary Language:
Height: Weight:

PRESCRIBER INFORMATION

Prescriber's Name:
State License #: NPI #:
DEA #:
Group or Hospital:
Address:
City: State: Zip:
Phone: Fax:
Contact Person: Phone:

INSURANCE INFORMATION: PLEASE FAX A COPY OF THE PRESCRIPTION & INSURANCE CARDS WITH THIS FORM, IF AVAILABLE (FRONT & BACK)

CLINICAL

Need By Date: **Ship to:** ☐ Patient ☐ Physician ☐ Other:

Date of Diagnosis: **Diagnosis:** ☐ M06.9 Rheumatoid Arthritis ☐ M45.9 Ankylosing Spondylitis ☐ L40.54 Psoriatic Arthritis ☐ M08 Juvenile Idiopathic Arthritis ☐ Non-radiographic Axial Spondyloarthritis ☐ New diagnosis ☐ Other:

Prior Medications: ☐ Acetaminophen, ibuprofen, naproxen, aspirin ☐ Humira ☐ Enbrel ☐ Methotrexate ☐ Corticosteroids ☐ Hydroxychloroquine ☐ Leflunomide ☐ Sulfasalazine ☐ Other meds tried:

Current Medications: **Is the patient also taking methotrexate?** ☐ Yes ☐ No

Allergies: **Is the patient new to therapy?** ☐ Yes ☐ No

Has patient had positive TB test? ☐ Yes ☐ No If yes, date of last chest x-ray: **Is a starter dose needed?** ☐ Yes ☐ No

PRESCRIPTION INFORMATION

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFIL
☐ Cimzia®	☐ Starter Kit (200 mg Prefilled Syringes)	☐ 400mg Sub-Q at weeks 0, 2, and 4	☐ 1 Kit = 6 x 200 mg/mL PFS	0
	☐ 200mg/ml Prefilled Syringe ☐ 200mg Vial	☐ 400mg Sub-Q every 4 weeks ☐ 200mg Sub-Q every 2 weeks ☐ Other:	☐ 1 Carton = 2 x 200 mg/mL PFS ☐ 1 Carton = 2 x 200 mg Vials	___
☐ Enbrel®	☐ 50mg/ml Sureclick™ ☐ 50mg/ml Prefilled Syringe ☐ 25mg/0.5ml Prefilled Syringe ☐ 25mg Vial	☐ Inject 50mg Sub-Q ONCE a week ☐ Inject 25mg Sub-Q TWICE a week (72-96 hours apart). ☐ Other:	☐ 4 ☐ 8	___
☐ Humira® (Citrate-free)	☐ 40mg/0.4mL CF Pen ☐ 40mg/0.4mL CF Prefilled Syringe ☐ 20mg/0.2mL CF Prefilled Syringe ☐ 10mg/0.1mL CF Prefilled Syringe	☐ Inject 40mg Sub-Q every OTHER week ☐ Inject 40mg Sub-Q every week ☐ Other:	☐ 2 pens/PFS ☐ 4 pens/PFS	___
☐ Humira®	☐ 40mg/0.8mL Pen ☐ 40mg/0.8mL Prefilled Syringe	☐ Inject 40mg Sub-Q every OTHER week ☐ Inject 40mg Sub-Q every week ☐ Other:	☐ 2 pens/PFS ☐ 4 pens/PFS	___
☐ Actemra®	☐ 162mg/0.9ml Prefilled Syringe ☐ 162mg/0.9mL ACTPen™	☐ Inject 162mg Sub-Q every OTHER week ☐ Inject 162mg Sub-Q every week	☐ 2 ☐ 4	___
☐ Orencia®	☐ 250mg Vial (IV use only)	☐ 10mg/kg IV x 1 dose, then 125mg Sub-Q weekly, start within 24hrs of IV dose ☐ Other:	☐ 1 Vial	___
	☐ 125 mg Prefilled Syringe	☐ 125mg Sub-Q ONCE a week	☐ 4 Syringes	___
	☐ 125 mg Autoinjector	☐ 125mg Sub-Q ONCE a week	☐ 4 Pens	___
☐ Simponi®	☐ 50mg/0.5ml Autoinjector ☐ 50mg/0.5ml Prefilled Syringe ☐ 100mg/ml Syringe ☐ 100mg/ml Autoinjector	☐ Inject 1 dose Sub-Q once monthly ☐ Other:	☐ 1 (one)	___
☐ Cosentyx®	☐ 150mg/mL Prefilled Syringe ☐ 150mg/mL Pen	☐ Starter Dose: Inject 300mg Sub-Q Day 1, Day 8, Day 15, Day 22, and then every 4 weeks starting on Day 29	☐ 8	0
		☐ Starter dose: Inject 150mg Sub-Q Day 1, Day 8, Day 15, Day 22, and then every 4 weeks starting on Day 29	☐ 4	0
		☐ Maintenance Dose: Inject the contents of 300mg Sub-Q starting Day 29 and then every 4 weeks thereafter	☐ 2	___
		☐ Maintenance Dose: Inject the contents of 150mg Sub-Q starting Day 29 and then every 4 weeks thereafter	☐ 2	___
☐ Taltz®	☐ 80mg/mL Autoinjector ☐ 80 mg/mL Prefilled Syringe	☐ Starter Dose: Inject 160 mg Sub-Q Day 1, followed by 80 mg every 4 weeks starting on Day 29	☐ 2	0
		☐ Maintenance Dose: Inject 80 mg Sub-Q starting Day 29 and then every 4 weeks thereafter	☐ 1	___

PHYSICIAN SIGNATURE REQUIRED

X _____ (Date) X _____ (Date)

PRODUCT SUBSTITUTION PERMITTED DISPENSE AS WRITTEN

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

Date Needed: _____ Medication Start Date: _____

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MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILL
☐ Stelara®	☐ 45mg/0.5mL Prefilled Syringe ☐ 90mg/1mL Prefilled Syringe	☐ Starter Dose: Inject 1 prefilled syringe Sub-Q Day 1 ☐ Maintenance Dose: Inject the contents of 1 prefilled syringe Sub-Q starting Day 29 & every 12 weeks thereafter	☐ 1 PFS ☐ 1 PFS	0 ___
☐ Xeljanz®	☐ 5mg Tab ☐ 11mg XR Tab	☐ Take one 5mg tablet PO twice daily ☐ Take one 11mg XR tablet PO once daily ☐ Other: _____	☐ 60 ☐ 30	___
☐ Otezla®	☐ Otezla Starter Kit ☐ Otezla 30mg Tablet	☐ Starter Dose: Take as directed per package instructions ☐ Maintenance Dose: Take 1 tablet by mouth twice daily	☐ 55 ☐ 60	0 ___
☐ Remicade®	☐ Remicade 100mg vial	☐ Induction: Infuse _____mg IV at weeks 0, 2, and 6 ☐ Maintenance: Infuse _____mg IV at every 8 weeks	☐ _____ # Vial(s)	___
☐ Kevzara®	☐ 150mg/1.14ml Prefilled Syringe ☐ 200mg/1.14ml Prefilled Syringe	☐ Inject 150mg Sub-Q every OTHER week ☐ Inject 200mg Sub-Q every OTHER week	☐ 2	___
☐ Olumiant®	☐ 1mg Tab ☐ 2mg Tab	☐ Take one 1mg tablet PO once daily ☐ Take one 2mg tablet PO once daily	☐ 30	___
☐ Rinvoq®	☐ 15 mg XR Tab	☐ Take one 15mg tablet PO once daily	☐ 30	___

PHYSICIAN SIGNATURE REQUIRED

X _____
PRODUCT SUBSTITUTION PERMITTED (Date)
Ancillary supplies and kits will be provided as needed for administration.

X _____
DISPENSE AS WRITTEN (Date)

Date Needed: _____ Medication Start Date: _____