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: _____
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 ☐ M08.9 Juvenile Arthritis
☐ M46.80 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	REFILL
☐ Actemra®	☐ 162mg/0.9mL Prefilled Syringe ☐ 162mg/0.9mL ACTPen™	☐ Inject 162mg Sub-Q every OTHER week	☐ 2 Pens/PFS	____
		☐ Inject 162mg Sub-Q every week	☐ 4 Pens/PFS	
☐ Benlysta®	☐ 200mg/mL Pen ☐ 200mg/mL Prefilled Syringe	☐ Starter Dose (Lupus Nephritis): Inject 400mg Sub-Q once weekly for 4 doses, then 200 mg once weekly thereafter	☐ 8 Pens/PFS	0
		☐ Maintenance Dose: Inject 200mg Sub-Q once weekly	☐ 4 Pens/PFS	____
☐ Cimzia®	☐ Starter Kit (200mg/mL Prefilled Syringes)	☐ Inject 400mg Sub-Q at weeks 0, 2, and 4	☐ 1 Kit = 6 x 200mg/mL PFS	0
	☐ 200mg/mL Prefilled Syringe ☐ 200mg Vial	☐ Inject 400mg Sub-Q every 4 weeks ☐ Inject 200mg Sub-Q every 2 weeks ☐ Other:_____	☐ 1 Carton = 2 x 200mg/mL PFS ☐ 1 Carton = 2 x 200mg Vials	____
☐ Cosentyx®	☐ 150mg/mL Prefilled Syringe ☐ 150mg/mL Sensoready 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 Pens/PFS	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 Pens/PFS	0
		☐ Maintenance Dose: Inject 300mg Sub-Q every 4 weeks	☐ 2 Pens/PFS	____
		☐ Maintenance Dose: Inject 150mg Sub-Q every 4 weeks	☐ 2 Pens/PFS	____
	☐ 75mg/0.5mL Prefilled Syringe (pediatric)	☐ Starter Dose (pediatric, 15-49 kg): Inject 75mg Sub-Q Day 1, Day 8, Day 15, and Day 22 and then every 4 weeks starting on Day 29	☐ 4 PFS	0
		☐ Maintenance Dose (pediatric, 15-49 kg): Inject 75 mg Sub-Q every 4 weeks	☐ 1 PFS	____
☐ Enbrel®	☐ 50mg/mL Sureclick™ ☐ 50mg/mL Prefilled Syringe ☐ 25mg/0.5mL Prefilled Syringe ☐ 50mg/mL Mini Cartridge ☐ 25mg/0.5mL Single-dose Vial	☐ Inject 50mg Sub-Q ONCE a week ☐ Inject 25mg Sub-Q TWICE a week (72-96 hours apart) ☐ Other:_____	☐ 4 ☐ 8	____
☐ 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	____
☐ 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 ☐ 80mg/0.8mL CF Pen	☐ Inject 40mg Sub-Q every OTHER week ☐ Inject 80mg SQ every OTHER week ☐ Inject 40mg Sub-Q every week ☐ Other:_____	☐ 2 Pens/PFS ☐ 4 Pens/PFS	____

X _____ PHYSICIAN SIGNATURE REQUIRED

PRODUCT SUBSTITUTION PERMITTED (Date)

X _____

DISPENSE AS WRITTEN (Date)

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
☐ Kevzara®	☐ 150mg/1.14mL Prefilled Syringe ☐ 200mg/1.14mL Prefilled Syringe ☐ 150mg/1.14mL Pen ☐ 200mg/1.14mL Pen	☐ Inject 150mg Sub-Q every OTHER week ☐ Inject 200mg Sub-Q every OTHER week	☐ 2 Pens/PFS	____
☐ Olumiant®	☐ 1mg Tab ☐ 2mg Tab	☐ Take one 1mg tablet PO once daily ☐ Take one 2mg tablet PO once daily	☐ 30	____
☐ Orencia®	☐ 250mg Vial (IV use only)	☐ ____mg IV x 1 dose, then 125mg Sub-Q weekly, start within 24hrs of IV dose ☐ Other:_____	☐ 1 Vial	____
	☐ 125mg/mL Prefilled Syringe ☐ 125mg/mL ClickJect	☐ Inject 125mg Sub-Q every week	☐ 4 Pens/PFS	____
	☐ 87.5mg/0.7mL Prefilled Syringe	☐ Inject 87.5mg Sub-Q every week ☐ Other:_____	☐ 4 PFS	____
	☐ 50mg/0.4mL Prefilled Syringe	☐ Inject 50mg Sub-Q every week ☐ Other: _____	☐ 4 PFS	____
☐ 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 Dose: Infuse _____mg IV at every 8 weeks	☐ _____ # Vial(s)	____
☐ Rinvoq®	☐ 15mg XR Tab	☐ Take one 15mg tablet PO once daily	☐ 30	____
☐ Simponi®	☐ 50mg/0.5mL SmartJect ☐ 50mg/0.5mL Prefilled Syringe ☐ 100mg/mL Syringe ☐ 100mg/mL SmartJect	☐ Inject 1 dose SubQ once monthly ☐ Other: _____	☐ 1 Pen/PFS	____
☐ Skyrizi®	☐ 150mg/mL Prefilled Syringe ☐ 150mg/mL Pen	☐ Starter Dose: Inject 150mg Sub-Q at week 0 and 4, followed by every 12 weeks thereafter	☐ 2 Pen/PFS	0
		☐ Maintenance Dose: Inject 150mg Sub-Q every 12 weeks.	☐ 1 Pen/PFS	____
☐ Stelara®	☐ 45mg/0.5mL Prefilled Syringe ☐ 90mg/mL Prefilled Syringe	☐ Starter Dose: Inject 1 prefilled syringe Sub-Q at weeks 0 and 4, and then every 12 weeks thereafter	☐ 1 PFS	0
		☐ Maintenance Dose: Inject 1 prefilled syringe Sub-Q every 12 weeks	☐ 1 PFS	____
☐ Taltz®	☐ 80mg/mL Autoinjector ☐ 80mg/mL Prefilled Syringe	☐ Starter Dose: Inject 160 mg Sub-Q Day 1, followed by 80mg every 4 weeks starting on Day 29	☐ 2 Pens/PFS	0
		☐ Maintenance Dose: Inject 80mg Sub-Q every 4 weeks	☐ 1 Pen/PFS	____
☐ Tremfya®	☐ 100mg/mL Prefilled Syringe ☐ 100mg/mL One-Press Injector	☐ Starter Dose: Inject 100mg Sub-Q at weeks 0, 4, and then every 8 weeks thereafter	☐ 1 Pen/PFS	0
		☐ Maintenance Dose: Inject 100mg Sub-Q every 8 weeks	☐ 1 Pen/PFS	____
☐ Xeljanz®	☐ 5mg Tab ☐ 11mg XR Tab ☐ 1mg/mL Oral Solution	☐ Take one 5mg tablet PO twice daily ☐ Take one 11mg XR tablet PO once daily ☐ Other:_____	☐ 60 ☐ 30 ☐ 240 mL Bottle	____

X _____ (Date) X _____ (Date)

PHYSICIAN SIGNATURE REQUIRED

PRODUCT SUBSTITUTION PERMITTED DISPENSE AS WRITTEN

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

Date Needed: _____ Medication Start Date: _____