



Rheumatology Enrollment Form

Phone: 855-425-4085

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ardonhealth.com

PATIENT INFORMATION	Patient Name: _____	PRESCRIBER INFORMATION	Prescriber's Name: _____
	Address: _____		State License #: _____ NPI #: _____
	City: _____ State: _____ Zip: _____		DEA #: _____
	Primary Phone: _____ DOB: _____		Group or Hospital: _____
	Alternate Phone: _____ Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		Address: _____
	Email: _____		City: _____ State: _____ Zip: _____
	Primary Language: _____		Phone: _____ Fax: _____
	Height: _____ Weight: _____		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: <input type="checkbox"/> Patient <input type="checkbox"/> Physician <input type="checkbox"/> Other: _____	Date of Diagnosis: _____
	Diagnosis: <input type="checkbox"/> M06.9 Rheumatoid Arthritis <input type="checkbox"/> M45.9 Ankylosing Spondylitis <input type="checkbox"/> L40.54 Psoriatic Arthritis <input type="checkbox"/> M08.9 Juvenile Arthritis	<input type="checkbox"/> Non-radiographic Axial Spondyloarthritis <input type="checkbox"/> New diagnosis <input type="checkbox"/> Other: _____	
	Prior 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"/> Leflunomide <input type="checkbox"/> Sulfasalazine <input type="checkbox"/> Other meds tried: _____	
	Current Medications: _____	Is the patient also taking methotrexate? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Allergies: _____	Is the patient new to therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Has patient had positive TB test? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date of last chest x-ray: _____	Is a starter dose needed? <input type="checkbox"/> Yes <input type="checkbox"/> No	

PRESCRIPTION INFORMATION	MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILL
PRESCRIPTION INFORMATION	<input type="checkbox"/> Actemra®	<input type="checkbox"/> 162mg/0.9mL Prefilled Syringe <input type="checkbox"/> 162mg/0.9mL ACTPen™	<input type="checkbox"/> Inject 162mg Sub-Q every OTHER week <input type="checkbox"/> Inject 162mg Sub-Q every week	<input type="checkbox"/> 2 Pens/PFS <input type="checkbox"/> 4 Pens/PFS	—
	<input type="checkbox"/> Cimzia®	<input type="checkbox"/> Starter Kit (200mg/mL Prefilled Syringes) <input type="checkbox"/> 200mg/mL Prefilled Syringe <input type="checkbox"/> 200mg Vial	<input type="checkbox"/> Inject 400mg Sub-Q at weeks 0, 2, and 4 <input type="checkbox"/> Inject 400mg Sub-Q every 4 weeks <input type="checkbox"/> Inject 200mg Sub-Q every 2 weeks <input type="checkbox"/> Other: _____	<input type="checkbox"/> 1 Kit = 6 x 200mg/mL PFS <input type="checkbox"/> 1 Carton = 2 x 200mg/mL PFS <input type="checkbox"/> 1 Carton = 2 x 200mg Vials	0 —
	<input type="checkbox"/> Cosentyx®	<input type="checkbox"/> 150mg/mL Prefilled Syringe <input type="checkbox"/> 150mg/mL Sensoready Pen	<input type="checkbox"/> Starter Dose: Inject 300mg Sub-Q Day 1, Day 8, Day 15, Day 22, and then every 4 weeks starting on Day 29 <input type="checkbox"/> Starter dose: Inject 150mg Sub-Q Day 1, Day 8, Day 15, Day 22, and then every 4 weeks starting on Day 29 <input type="checkbox"/> Maintenance Dose: Inject 300mg Sub-Q every 4 weeks <input type="checkbox"/> Maintenance Dose: Inject 150mg Sub-Q every 4 weeks	<input type="checkbox"/> 8 Pens/PFS <input type="checkbox"/> 4 Pens/PFS <input type="checkbox"/> 2 Pens/PFS <input type="checkbox"/> 2 Pens/PFS	0 0 — —
	<input type="checkbox"/> Enbrel®	<input type="checkbox"/> 50mg/mL Sureclick™ <input type="checkbox"/> 50mg/mL Prefilled Syringe <input type="checkbox"/> 25mg/0.5mL Prefilled Syringe <input type="checkbox"/> 50mg/mL Mini Cartridge <input type="checkbox"/> 25mg Multiple-dose Vial <input type="checkbox"/> 25mg/0.5mL Single-dose Vial	<input type="checkbox"/> Inject 50mg Sub-Q ONCE a week <input type="checkbox"/> Inject 25mg Sub-Q TWICE a week (72-96 hours apart) <input type="checkbox"/> Other: _____	<input type="checkbox"/> 4 <input type="checkbox"/> 8	—
	<input type="checkbox"/> Humira®	<input type="checkbox"/> 40mg/0.8mL Pen <input type="checkbox"/> 40mg/0.8mL Prefilled Syringe	<input type="checkbox"/> Inject 40mg Sub-Q every OTHER week <input type="checkbox"/> Inject 40mg Sub-Q every week <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"/> 40mg/0.4mL CF Pen <input type="checkbox"/> 40mg/0.4mL CF Prefilled Syringe <input type="checkbox"/> 20mg/0.2mL CF Prefilled Syringe <input type="checkbox"/> 10mg/0.1mL CF Prefilled Syringe <input type="checkbox"/> 80mg/0.8mL CF Pen	<input type="checkbox"/> Inject 40mg Sub-Q every OTHER week <input type="checkbox"/> Inject 40mg Sub-Q every week <input type="checkbox"/> Other: _____	<input type="checkbox"/> 2 Pens/PFS <input type="checkbox"/> 4 Pens/PFS	—
	<input type="checkbox"/> Kevzara®	<input type="checkbox"/> 150mg/1.14mL Prefilled Syringe <input type="checkbox"/> 200mg/1.14mL Prefilled Syringe	<input type="checkbox"/> Inject 150mg Sub-Q every OTHER week <input type="checkbox"/> Inject 200mg Sub-Q every OTHER week	<input type="checkbox"/> 2 PFS	—

PHYSICIAN SIGNATURE REQUIRED

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

Date Needed: _____ Medication Start Date: _____

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PRESCRIPTION INFORMATION

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILL
<input type="checkbox"/> Olumiant®	<input type="checkbox"/> 1mg Tab <input type="checkbox"/> 2mg Tab	<input type="checkbox"/> Take one 1mg tablet PO once daily <input type="checkbox"/> Take one 2mg tablet PO once daily	<input type="checkbox"/> 30	—
<input type="checkbox"/> Orencia®	<input type="checkbox"/> 250mg Vial (IV use only)	<input type="checkbox"/> 10mg/kg IV x 1 dose, then 125mg Sub-Q weekly, start within 24hrs of IV dose <input type="checkbox"/> Other: _____	<input type="checkbox"/> 1 Vial	—
	<input type="checkbox"/> 125mg/mL Prefilled Syringe <input type="checkbox"/> 125mg/mL ClickJect	<input type="checkbox"/> Inject 125mg Sub-Q every week	<input type="checkbox"/> 4 Pens/PFS	—
	<input type="checkbox"/> 87.5mg/0.7mL Prefilled Syringe	<input type="checkbox"/> Inject 87.5mg Sub-Q every week <input type="checkbox"/> Other: _____	<input type="checkbox"/> 4 PFS	—
	<input type="checkbox"/> 50mg/0.4mL Prefilled Syringe	<input type="checkbox"/> Inject 50mg Sub-Q every week <input type="checkbox"/> Other: _____	<input type="checkbox"/> 4 PFS	—
<input type="checkbox"/> Otezla®	<input type="checkbox"/> Otezla Starter Kit <input type="checkbox"/> Otezla 30mg Tablet	<input type="checkbox"/> Starter Dose: Take as directed per package instructions <input type="checkbox"/> Maintenance Dose: Take 1 tablet by mouth twice daily	<input type="checkbox"/> 55 <input type="checkbox"/> 60	0 —
<input type="checkbox"/> Remicade®	<input type="checkbox"/> Remicade 100mg Vial	<input type="checkbox"/> Induction: Infuse ____mg IV at weeks 0, 2, and 6 <input type="checkbox"/> Maintenance Dose: Infuse ____mg IV at every 8 weeks	<input type="checkbox"/> ____ # Vial(s)	—
<input type="checkbox"/> Rinvoq®	<input type="checkbox"/> 15mg XR Tab	<input type="checkbox"/> Take one 15mg tablet PO once daily	<input type="checkbox"/> 30	—
<input type="checkbox"/> Simponi®	<input type="checkbox"/> 50mg/0.5mL SmartJect <input type="checkbox"/> 50mg/0.5mL Prefilled Syringe <input type="checkbox"/> 100mg/mL Syringe <input type="checkbox"/> 100mg/mL SmartJect	<input type="checkbox"/> Inject 1 dose SubQ once monthly <input type="checkbox"/> Other: _____	<input type="checkbox"/> 1 Pen/PFS	—
	<input type="checkbox"/> 45mg/0.5mL Prefilled Syringe <input type="checkbox"/> 90mg/mL Prefilled Syringe	<input type="checkbox"/> Starter Dose: Inject 1 prefilled syringe Sub-Q at weeks 0 and 4, and then every 12 weeks thereafter <input type="checkbox"/> Maintenance Dose: Inject 1 prefilled syringe Sub-Q every 12 weeks	<input type="checkbox"/> 1 PFS <input type="checkbox"/> 1 PFS	0 —
<input type="checkbox"/> Taltz®	<input type="checkbox"/> 80mg/mL Autoinjector <input type="checkbox"/> 80mg/mL Prefilled Syringe	<input type="checkbox"/> Starter Dose: Inject 160 mg Sub-Q Day 1, followed by 80mg every 4 weeks starting on Day 29 <input type="checkbox"/> Maintenance Dose: Inject 80mg Sub-Q every 4 weeks	<input type="checkbox"/> 2 Pens/PFS <input type="checkbox"/> 1 Pen/PFS	0 —
	<input type="checkbox"/> 100mg/mL Prefilled Syringe <input type="checkbox"/> 100mg/mL One-Press Injector	<input type="checkbox"/> Starter Dose: Inject 100mg Sub-Q at weeks 0, 4, and then every 8 weeks thereafter <input type="checkbox"/> Maintenance Dose: Inject 100mg Sub-Q every 8 weeks	<input type="checkbox"/> 1 Pen/PFS <input type="checkbox"/> 1 Pen/PFS	0 —
<input type="checkbox"/> Xeljanz®	<input type="checkbox"/> 5mg Tab <input type="checkbox"/> 11mg XR Tab	<input type="checkbox"/> Take one 5mg tablet PO twice daily <input type="checkbox"/> Take one 11mg XR tablet PO once daily <input type="checkbox"/> Other: _____	<input type="checkbox"/> 60 <input type="checkbox"/> 30	—

X

PHYSICIAN SIGNATURE REQUIRED

X

PRODUCT SUBSTITUTION PERMITTED

(Date)

DISPENSE AS WRITTEN

(Date)

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

Date Needed: _____ Medication Start Date: _____

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This prescription is valid only if transmitted by facsimile machine by a licensed provider