DR IKE'S SPECIALTY PHARMACY

Rheumatology ENROLLMENT FORM A-M

P: 818.578.7400 | F: 888-804-7717 | www.drikesp.com | NPI: 1154712305

1 Prescriber Information

Practice Name: _____ Tax ID: _____

Prescriber Practitioner: _____ NPI: _____

Supervising Physician: _____ NPI: _____

Address: _____ City: _____ State: _____ Zip: _____

Office Contact: _____ Phone: _____ Fax: _____

(Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy, and cannot fax these referral forms to Dr. Ike's Specialty Care.)

2 Patient Information

(This prescription form is to be sent and received via fax.)

Name: _____ DOB: _____ SS#: _____ ☐ M ☐ F

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Alt. Phone: _____ ☐ English ☐ Spanish ☐ Other Wt. _____ Ht. _____

3 Prescription

☐ New ☐ Refill SHIP BY: _____ SHIP TO: ☐ PATIENT'S HOME ☐ DOCTOR'S OFFICE ☐ OTHER: _____

DRUG		DIRECTIONS & QUANTITY		REFILLS
Actemra®	☐ ACTPen™ ☐ Pre-filled Syringe ☐ Vials	☐ IV: Infuse _____ mg OR _____ mg/kg via IV every 4 weeks ☐ SQ: Inject 162mg SQ every other week *(Quantity: 2)* ☐ SQ: Inject 162mg SQ every week *(Quantity: 4)*		
Cimzia®	☐ Pre-filled Syringe ☐ Vials	☐ INITIAL: Inject 400mg SQ on Day 0, Day 14, and Day 28 *(Quantity: 6)* ☐ MAINTENANCE: Inject 400mg SQ every 4 weeks *(Quantity: 2)* ☐ MAINTENANCE: Inject 200mg SQ every 2 weeks *(Quantity: 2)*		
Cosentyx™	☐ Sensoready Pen ☐ Pre-filled Syringe	☐ INITIAL: Inject 150mg SQ on week 0, 1, 2, 3 and 4 *(Quantity: 5)*	☐ MAINTENANCE: Inject 150mg SQ every 4 weeks *(Quantity: 1)*	
		☐ INITIAL: Inject 300mg SQ on week 0, 1, 2, 3 and 4 *(Quantity: 10)*	☐ MAINTENANCE: Inject 300mg SQ every 4 weeks *(Quantity: 2)*	
Enbrel®	☐ SureClick® Pen ☐ Mini™ with AutoTouch™ ☐ Pre-filled Syringe ☐ 25mg ☐ 50mg ☐ Vials 25mg	☐ Inject 50mg SQ every week *(Quantity: 4)* ☐ Inject 25mg SQ twice weekly 72-96 hours apart *(Quantity: 8)*		
Humira® *(Citrate Free)*	☐ Uveitis Starter Kit ☐ Pen ☐ Pre-filled Syringe	☐ UVEITIS INITIAL: Inject 80mg SQ on Day 1, 40mg on Day 8, then 40mg every other week *(Quantity: 3)* ☐ MAINTENANCE: Inject 40 mg SQ every two weeks *(Quantity: 2)* ☐ MAINTENANCE: Inject 40 mg SQ weekly *(Quantity: 4)*		
Humira®	☐ Uveitis Starter Kit ☐ Pen ☐ Pre-filled Syringe	☐ UVEITIS INITIAL: Inject 80mg SQ on Day 1, 40mg on Day 8, then 40mg every other week *(Quantity: 3)* ☐ MAINTENANCE: Inject 40 mg SQ every two weeks *(Quantity: 2)* ☐ MAINTENANCE: Inject 40 mg SQ weekly *(Quantity: 4)*		

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:
☐ Cimzia	☐ _____	☐
☐ Enbrel	☐ _____	☐
☐ Humira	☐ _____	☐
☐ Methotrexate	☐ _____	☐
☐ NSAID	☐ _____	☐
☐ Plaquenil	☐ _____	☐
☐ Other _____	☐ _____	☐

☐ H20.9 Unspecified Iridocyclitis

☐ H20.0 Iridocyclitis (Uveitis), Unspecified Acute and Subacute

☐ M06.9 Rheumatoid Arthritis, Unspecified

☐ M05.9 Rheumatoid Arthritis with Rheumatoid Factor, Unspecified

☐ M31.6 Other Giant Cell Arteritis

☐ M06.09 Rheumatoid Arthritis without Rheumatoid Factor, multiple sites

☐ M05.79 Rheumatoid Arthritis with rheumatoid factor of mult. sites w/o organ or system involvement

☐ M31.5 Giant Cell Arteritis with Polymyalgia Rheumatica

☐ Other _____

Date of Diagnosis: _____ **Allergies:** _____

Active TB is ruled out: ☐ Yes ☐ No Date: _____ Hep B ruled out/treated: ☐ Yes ☐ No Date: _____

Additional Clinical Information: _____

To Prescribing Practitioner: *By signing this form and utilizing our services, you are also authorizing Dr. Ike's Specialty Pharmacy to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies, and co-pay assistance foundations.*

Prescriber's Signature: _____ Date: _____

DR IKE'S SPECIALTY PHARMACY

Rheumatology ENROLLMENT FORM N-Z

P: 818.578.7400 | F: 888-804-7717 | www.drikesp.com | NPI: 1154712305

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Prescriber Practitioner: _____ NPI: _____

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2 Patient Information

(This prescription form is to be sent and received via fax.)

Name: _____ DOB: _____ SS#: _____ ☐ M ☐ F

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Alt. Phone: _____ ☐ English ☐ Spanish ☐ Other Wt. _____ Ht. _____

3 Prescription

☐ New ☐ Refill SHIP BY: _____ SHIP TO: ☐ PATIENT'S HOME ☐ DOCTOR'S OFFICE ☐ OTHER: _____

DRUG		DIRECTIONS & QUANTITY	REFILLS
Olumiant®	☐ 1mg Tablets GFR Required: _____ ☐ 2mg Tablets	☐ Take 1mg PO once daily *(Quantity: 30)* ***Dosing intended for patients with moderate renal impairment*** ☐ Take 2mg PO once daily *(Quantity: 30)*	
Orencia®	☐ 250mg Vials ☐ Pre-filled Syringe ☐ ClickJect™	**INTRAVENOUS (IV):** ☐ INITIAL: Infuse _____ mg via IV on week 0, 2, and 4 *(Quantity: QS 3 doses)* ☐ MAINTENANCE: Infuse _____ mg via IV every 4 weeks *(Quantity: QS 1 doses)* **SUBCUTANEOUS (SQ):** ☐ Inject 125mg SQ once weekly *(Quantity: 4)*	
Otezla®	☐ 28 Day Starter Pack ☐ Maintenance ☐ Bridge Dose Pack	☐ Take as directed per package instructions *(Quantity: 55)* ☐ Take 30mg PO twice daily *(Quantity: 60)* ☐ Take 30 mg PO twice daily *(Quantity: 28)*	
Rinvoq™	☐ 15mg Tablets	☐ Take 15 mg PO once daily *(Quantity: 30)*	
Simponi®	☐ SmartJect® *(Pen)* ☐ Pre-filled Syringe	☐ Inject 50 mg SQ once a month *(Quantity: 1)*	
Simponi Aria®	☐ 5mg Tablets	☐ INITIAL: Infuse 2mg/kg via IV over 30 minutes at weeks 0 and 4 *(Quantity: QS 2 doses)* ☐ MAINTENANCE: Infuse 2mg/kg via IV over 30 minutes every 8 weeks thereafter *(Quantity: QS 1 doses)*	
Xeljanz®	☐ 5mg Tablets	☐ Take 5mg PO twice daily *(Quantity: 60)*	
Xeljanz® XR	☐ 11mg Tablets	☐ Take 11mg PO once daily *(Quantity: 30)*	
Other	_____	_____	_____

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:
☐ Cimzia	☐ _____	☐
☐ Enbrel	☐ _____	☐
☐ Humira	☐ _____	☐
☐ Methotrexate	☐ _____	☐
☐ Plaquenil	☐ _____	☐
☐ Tramadol	☐ _____	☐
☐ Other _____	☐ _____	☐

☐ M05.9 Rheumatoid Arthritis with Rheumatoid Factor, Unspecified

☐ M05.79 Rheumatoid Arthritis with Rheumatoid Factor of mult. sites w/o organ or system involvement

☐ M06.9 Rheumatoid Arthritis, Unspecified

☐ M06.09 Rheumatoid Arthritis without Rheumatoid Factor, multiple sites

☐ M35.2 Behcet's disease

☐ Other: _____

Date of Diagnosis: _____ **Allergies:** _____

Active TB is ruled out: ☐ Yes ☐ No Date: _____ Hep B ruled out/treated: ☐ Yes ☐ No Date: _____

Additional Clinical Information: _____

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Prescriber's Signature: _____ Date: _____