Wellness Pharmacy AND COMPOUNDING CENTER

RHEUMATOLOGY FORM (DRUGS A-M)

Phone: 919-964-5656 | Fax: 919-964-5757
www.wellnessraleigh.com

PATIENT INFORMATION

- ◯ New Patient ◯ Current Patient
- ◯ New Rx ◯ Refill
- ◯ Medicare/Medicaid

Primary Caregiver: _____

PACKAGING

- ◯ Wellness Pharmacy Packaging
- ◯ Vials (Childproof ◯ Yes ◯ No)

DELIVERY/PICK-UP OPTIONS

- ◯ Patient's Home ◯ Pharmacy Pickup
- ◯ MD's Office
- ◯ MD's office 1st dose at MD's office and remaining refills at patient's home

Date Required: _____

PATIENT INFORMATION

Last Name, First Name _____ Primary Language _____

Primary Phone Number _____ Alternate Phone Number _____

Home Address _____ City, State _____ Zip _____

Shipping Address (if different from home address) _____

Social Security Number _____ Date of Birth _____

Height _____ Weight _____ BMI _____ Gender ◯ M ◯ F Pregnant ◯ Yes ◯ No

PRESCRIBER INFORMATION

Today's Date _____

Physician Name _____ NPI # _____

State License # _____ DEA # _____

Address _____ City, State _____ Zip _____

Phone Number _____ Fax Number _____

Key Office Contact Name _____ Email _____

CLINIC INFORMATION | PLEASE FAX LABS, CURRENT PRESCRIPTION MEDICATIONS/OTC PROFILE, AND HISTORY

Diagnosis: ☐ 714.0 Rheumatoid Arthritis ☐ 696.0 Psoriatic Artrithis ☐ 720.0 Ankylosing Spondylitis ☐ Other _____ Date of Diagnosis: _____

Prior Medications: ☐ Acetaminophen, ibuprofen, naproxen, aspirin ☐ Humira ☐ Enbrel ☐ Methotrexate ☐ Corticosteroids ☐ Celebrex ☐ Indocin ☐ Azulfidine

☐ Other medications tried: _____ Additional justification for medication: _____

Current Medications: _____ Is the patient also taking methotrexate? ◯ Yes ◯ No

PRESCRIPTION INFORMATION OR ATTACH RX

MEDICATION	DOSAGE/STRENGTH	USAGE DIRECTIONS	QUANTITY	REFILLS
☐ Actemra ®	☐ 162 mg/0.9 mL Prefilled Syringe	☐ 162 mg Sub-Q every other week ☐ 125mg Sub-Q ONCE a week	☐ 2 PFS ☐ 4 PFS	
☐ Cimzia ®	**Starter Dose** ☐ Starter Kit (200 mg Prefilled Syringes) ☐ 200mg Lyophilized Vial **Maintenance Dose** ☐ 200mg/ml Prefilled Syringe ☐ 200mg Lyophilized Vial	☐ 400mg Sub-Q at weeks 0,2, and 4 ☐ 400mg Sub-Q every 4 weeks ☐ 200mg Sub-Q every 2 weeks	☐ 1 Kit = 6x200 mg/mL PFS ☐ 3 Kits = 3 cartons of 2x 200 mg Vials ☐ 1 Carton = 2 x 200 mg/mL PFS ☐ 1 Carton = 2x200 mg vials	
☐ Enbrel ®	☐ 50mg/ml Sureclick™ ☐ 50 mg/ml Prefilled Syringe ☐ 25mg Vial (inj. Supplies incl)	☐ Inject 50mg Sub-Q ONCE a week ☐ Inject 25mg Sub-Q TWICE a week		
☐ Humira ®	☐ 40mg/0.8ml PEN ☐ 40mg/0.8ml Prefilled Syringe	☐ Inject 40mg Su-Q every OTHER week ☐ Inject 40mg Sub-Q ONCE a week	☐ 2 ☐ 4	
☐ Kevzara ® (sarilumab) ®	☐ Inject 150 mg subcut every other week ☐ Inject 200 mg subcut every other week	☐ 2 x 200 mg/1.14mL ☐ 2 x 200 mg/1.14mL	☐ PFS ☐ PFS	

I hereby authorize **Wellness Pharmacy and Compounding Center** and its representatives to act as a prior authorization designated agent. I authorize them to deal with medical and prescription insurance companies and to organize/receive patient lab values.

◯ Patient is interested in Patient Support Programs as necessary/applicable

Ancillary kits and supplies provided as necessary/applicable

Doctor/Prescriber Name - Dispense as Written _____ Date _____ Doctor/Prescriber Name - Substitution Permissible _____ Date _____

PATIENT SUPORT | PLEASE FAX COPIES OF INSURANCE, PRESCRIPTION AND / OR CO-PAY CARD

Enbrel Injection Training or Nurse Support: ENBREL Support™ RN to provide education & training ☐ No Nurse

Humira Injection Training or Nurse Support: *Physician Signature required for Injection Training* my Humira Nurse (RN) visit to provide education & training: Patient's Home or Clinic Site ☐ Physician's Office ☐ No Nurse

Simponi Injection Training or Nurse Support: SimponiOne RN to provide education & training for Sub-Q injection ☐ No Nurse

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