Carepoint™
A Pharmacy That Truly Cares

Rheumatology Therapy Enrollment

www.carepointrx.com
Fax: 855-237-9113 | Toll Free: 855-237-9112
E-Prescribe: NCPDP 1487330 | NPI 1598013864

PATIENT

PLEASE INCLUDE FACE SHEET & ALL INSURANCE CARDS

Name ____________________ DOB ______________ Phone ____________________

Address ____________________ City, State ____________________ Zip __________

MEDICAL ASSESSMENT

DATE: ______________ Height & Weight: ______________ Allergies: ____________________

☐ M06.9 Rheumatoid Arthritis ☐ M81.0 Osteoporosis ☐ M08.0 Juvenile Idiopathic Arthritis

☐ L40.59 Psoriatic Arthritis ☐ M19.9 Osteoarthritis ☐ M45.9 Ankylosing Spondylitis ☐ Other: ____________________

TB/PPD Test? Result: _______ **History of Cancer?** ☐ Yes ☐ No **Secondary infection?** ____________________

Current Medications: ____________________

Prior Therapies:	Reason for Discontinuation:	Appx. Start Date:	Appx. End Date:

PRESCRIPTION

Quantity/Refills:

Actemra®	☐ 162mg prefilled syringe	Inject 162mg subcutaneously: ☐ ONCE WEEKLY ☐ EVERY OTHER WEEK	4 weeks / ______
Cimzia®	☐ Starter Pack (6 x 200mg PFS)	Inject 400mg SC weekly at week 0, week 2 and week 4	1 pack / 0
	☐ Maintenance Pack (2x 200mg PFS)	☐ Inject 200mg subcutaneously once every OTHER week ☐ Inject 400mg subcutaneously once every FOUR weeks	4 weeks / ______
Enbrel®	☐ 50mg SureClick ☐ 50mg syringe	Inject 50mg subcutaneously once weekly	4 weeks / ______
Forteo®	☐ 28-dose (20mcg each) prefilled pen	Inject 20mcg subcutaneously once daily	4 weeks / ______
Humira®	☐ 40mg pen ☐ 40mg vial	Inject 40mg subcutaneously: ☐ ONCE WEEKLY ☐ EVERY OTHER WEEK	4 weeks / ______
Kineret®	☐ 100mg prefilled syringes	Inject 100mg subcutaneously every day	4 weeks / ______
Orencia®	☐ 125mg prefilled syringe	Inject 125mg subcutaneously once weekly	4 weeks / ______
Orencia IV®	☐ 250mg vial	Infuse ☐ 500mg ☐ 750mg ☐ 1000mg at week 0, week 2 and week 4	4 weeks / 0
		Infuse ☐ 500mg ☐ 750mg ☐ 1000mg every 4 weeks	4 weeks / ______
Otezla®	☐ Starter Pack	☐ Take as directed per package instructions (6-day titration)	1 pack / 0
	☐ Maintenance Pack (30mg)	☐ Take 30mg by mouth twice daily	4 weeks / ______
Otrexup®	☐ 0.4ml prefilled auto-injector	Inject: ☐ 7.5mg ☐ 10mg ☐ 15mg ☐ 20mg ☐ 25mg SC once weekly	4 weeks / ______
Prolia®	☐ 60mg prefilled syringe	Inject 60mg subcutaneously once every 6 months	4 weeks / ______
Remicade®	☐ 100mg/20ml vial ☐ ***Please arrange home nursing***	☐ Infuse ______mg IV at week 0, week 2 and week 6 ☐ Infuse ______mg IV every ______	4 weeks / ______
Simponi®	☐ 50mg prefilled syringe	Inject 50mg subcutaneously once monthly	4 weeks / ______
Stelara®	☐ 45mg syringe (< 220 lbs.) ☐ 90mg syringe (> 220 lbs.)	☐ Inject ______mg subcutaneously on day 0 ☐ Inject ______mg subcutaneously at week 4, then every 12 weeks	4 weeks / ______
Xeljanz® or Xeljanz XR®	☐ 5mg tablets ☐ 11mg extended-release tablets	☐ Take 5mg by mouth twice daily ☐ Take 11mg by mouth once daily	30 days / ______
OTHER:	☐ Methotrexate ☐ Sulfasalazine ☐	☐ Sig: ____________________	______ / ______

☒ Dispense sufficient quantity of all necessary supplies (syringes, needles, alcohol wipes, etc.) for proper medication administration

PROVIDER

PLEASE INCLUDE ALL RECENT LABS & CLINICAL NOTES

Prescriber Name ____________________ Phone ______________ Fax ______________

____________________ (______________) ____________________

Prescriber Signature ***NPI or DEA*** ***In-Office Contact Person***

**By signing this form and utilizing our services, you authorize Carepoint and its employees to serve as your designated agent for handling prior authorizations and other medical and prescription insurance forms and communications*