Orchard Specialty PHARMACY SERVICES

Phone: 1-877-437-9012 *Fax 1-877-309-0687*

Prescription and Rheumatology Enrollment Form

Patient Information

Patient Name: _____
Date of Birth: _____ Sex: _____ SS#_____
Address: _____
City: _____State:_____Zip:_____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ E-mail:_____
Please attach copy of front and back of patient's prescription ins. card(s) if applicable
Insurance Company Name: _____
Insurance Company Phone: _____
Policy holder:_____
Policy holder Employer:_____
Relationship to Patient:_____
ID# _____Group#_____
RxBIN: _____RxPCN:_____
Credit Card: ___Visa ___Mastercard ___AmEx ___Discover
Card Number: _ _ _ _-_ _ _ _-_ _ _ _-_ _ _ _ Exp. Date: _ _- _ _ _ _
Card Security Code-CVV: _ _ _ _ (3 or 4 digits on back of card)
If a credit card is selected for payment you authorize Orchard to process amount of order on the designated card.
Signature: _____

Prescriber Information

Physician Name:_____
Address:_____
City: _____State: _____ Zip: _____
Phone#:_____Fax#:_____
DEA#_____NPI#_____
License#:_____Medicaid UPIN#:_____
Physician Specialty: _____
Date prescription written:_____
Physician Signature (no stamps):_____
If physician requests Brand Name only, DAW MUST be HANDWRITTEN in the following space provided:
Date Shipment Needed:_____ Ship to: ___Patient ___Dr.
Shipment Address:_____
City: _____State: _____Zip:_____
If shipped to the physician's office, physician accepts on behalf of patient for administration in office.

Clinical Information and Prescription

Diagnosis: ___714.0 Rheumatoid Arthritis ___720.0 Akylosing Spondylitis
___696.0 Psoriatic Arthritis ___Other:_____
Date of Diagnosis or Years with Disease: _____
Patients Allergies: _____
DAS Score:_____ Clinical Stage:_____ Functional Status:_____
Latex allergy: _____yes ___no
Patient Weight: _____ Patient Height: _____
Has the patient had a NEGATIVE tuberculin skin test?: ___yes ___no
if yes has therapy been initiated? ___yes ___no
Has Hepatitis B been ruled out? ___Yes ___No If No, has treatment been initiated? ___Yes ___No
Prior DMARD's and length of treatment:
_____
_____

Enbrel®(etanercept)
Dose :___ 25mg prefilled syringe ___ 25mg multiuse vial ___ 50mg prefilled syringe ___ 50mg SureClick
Dispense: ___ once per week ___ twice per week ___ (JIA) inject 0.8mg/kg, max 50mg/week

Humira®(adalimumab)
Dose: ___40mg/0.8ml PFS ___40mg/0.8ml pens ___20mg/0.4ml PFS
Dispense: ___ 40mg SC every other week (also JIA, pat. weight>30kg)
___20mg SC every other week (pat. weight 15kg to <30kg, JIA)

Kineret®(anakinra) Inject 100mg SC every day

Orencia®(abatacept)infuse over 30 minutes as directed
Dose: ___500mg (pat. <60kg) ___750mg (60-100kg) ___1000mg (>100kg) ___10mg/kg if less than 75kg (JA)

Remicade®(infliximab)infuse NS 250ml over 2 hours as directed
Dose: ___3mg/kg @ 0, 2, 6 weeks ___3mg/kg every 8 weeks
___5mg/kg @ 0, 2, 6 weeks then every 6 weeks thereafter (Ankylosing Spon.)
___Other Remicade dosing: _____

Rituxan®(rituximab)infuse 1000mg IV bolus on day 1 and 15.

Simponi® (golimumab)inject 50mg subcutaneously once per month
Dose: ___50mg/0.5ml SmartJect™ ___ 50mg/0.5ml prefilled syringe

Cimzia®(certolizumab)
Initial Dose: ___400mg SC @ 0, 2, 4 weeks prefilled syringe
___400mg SC @ 0, 2, 4 weeks lyophilized powder (administered in office)
Maintenance Dose: ____ 400mg SC every 4 weeks ___400mg SC every 2 weeks

Dispense: ___ Quantity sufficient for 1 month supply Refill: _____times