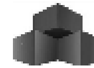
RHEUMATOID ARTHRITIS ENROLLMENT FORM

PHONE: 800-361-1260
FAX: 800-737-4920



CORNERSTONE PHARMACY
an affiliate of

PATIENT INFORMATION (PLEASE PRINT)

Patient Name (Last, First, Mi)			☐ Male ☐ Female
Date of Birth (mm/dd/yyyy)	SS#	Phone (Daytime)	Phone (Evening)
Street Address (Please include Suite/Apt Number)	City	State	Zip

INSURANCE INFORMATION (PLEASE ATTACH COPY OF PATIENT'S PHARMACY BENEFIT CARD - FRONT AND BACK)

Primary Insurance	Policy #	Group #	Policy Holder	Phone

DIAGNOSIS / MEDICAL INFORMATION (Please indicate primary and secondary diagnosis)

☐ 714.0 Rheumatoid Arthritis	☐ 696.0 Psoriasis Arthritis	☐ Other ICD9 __________	Is patient new to therapy? ☐ yes ☐ no Date of Dx: __ /__/___

Patient tested for TB: ☐ yes ☐ no If yes, Date ____/____/______ Result: ☐ Positive ☐ Negative

Patient Weight: ______________________ **Drug Allergies:** ________________________ **OR** ☐ NKDA

PREVIOUS MEDICATIONS (Please specify dosage and time on therapy)

Medication Strength and Dose	*Date of Therapy*	*Reason for Discontinuing*

PRESCRIPTION INFORMATION

Medication	***Dose / Strength***	***Directions***	***Quantity***	***Refills***
☐ Actemra® (tocilizumab)	☐ 80mg/4ml ☐ 200mg/10ml ☐ 400mg/20ml _______mg/kg	☐ Induction Dose: 4mg/kg every 4 weeks ☐ Maintenance Dose: 8mg/kg every 4 weeks ☐ Other: ___________________________		
☐ Cimzia® (certolizumab-pegol)	☐ Cimzia® Starter Kit 6 - 200mg prefilled syringes	☐ Induction Dose: Two(#2) 200 mg prefilled syringes day SC (400mg); and Two (#2) 200 mg prefilled syringes SC (400mg) at end of week 2; and Two (#2) 200 mg prefilled syringes SC (400mg) at end of week 4	1 kit	0
	☐ 200 mg prefilled syringes ☐ 200 mg vials	☐ Maintenance Dose: 200mg SC every OTHER week (every 2 weeks) ☐ Maintenance Dose: 400mg SC every 4 weeks – inject #2 syringes ☐ Other: ____________________________________		
☐ Enbrel® (etanercept)	☐ 50 mg/ml pre-filled syringe ☐ 50 mg/ml SureClick™ Auto Syringe ☐ 25 mg/0.5ml pre-filled syringe ☐ 25 mg vial	☐ 50mg SC once a week ☐ 25mg SC twice a week (3-4 days apart) ☐ 25mg SC twice a week		
☐ Humira® (adalimumab)	☐ 40mg Pen Auto Syringe ☐ 40mg prefilled syringe ☐ 20mg prefilled syringe	☐ 40mg SC every OTHER week ☐ 20mg SC every OTHER week ☐ Other:		
☐ Kineret® (anakinra)	☐ 100mg prefilled syringe	☐ 100mg (1 syringe) SC once a day		
☐ Orencia® (abatecept)	☐ 250mg vial — Not for self-administration	☐ Infuse ____mg in 100ml 0.9% NaCl at weeks 0,2 and 4; then every 4 weeks		
	☐ 125mg/ml subcutaneous prefilled syringe	☐ 125mg SC once weekly		
☐ Remicade® (infliximab)	☐ 100mg vials # of vials _______ Not for self-administration	☐ Infuse 3mg/kg in 250ml 0.9% NaCl as directed ☐ Other ____________________________		
☐ Rituxan® (rituximab)	☐ 100mg/10ml vial ☐ 500mg/50ml vial Not for self-administration	☐ __________________________________		
☐ Simponi™ (golimumab)	☐ 50mg/0.5ml pre-filled syringe ☐ 50mg/0.5ml SmartJect™	☐ 50mg SQ Once Monthly ☐ Other:_____________		
☐ Xeljanz™ (tofacitinib)	☐ 5mg tablet	☐ Take one 5mg by mouth twice daily ☐ Other:_____________________		
☐ Other				

DELIVERY AND PATIENT EDUCATION INSTRUCTIONS

☐ Patient's Home	☐ Physician's Office	Date Needed: ___ / ___ / _____	Patient needs Teaching/Education Kit? ☐ yes ☐ no

PHYSICIAN CONTACT INFORMATION AND AUTHORIZATION

Physician Name	License #	DEA #	UPIN #
Office Contact	Phone	Fax	NPI#
Street Address (Please include Suite Number)	City/State/Zip		
Physician's Signature (required)		**Date (required)**	

This prescription will be filled generically unless Prescriber writes "DAW" in the box to the right. ☐