Rheumatology Enrollment Form A-G

Please fax the completed form to

601-420-4040

TRANSCRIPT PHARMACY

Signature Care Program

2506 Lakeland Drive
Flowood, MS 39232
Phone: 866-420-4041
Fax: 601-420-4040
www.transcriptpharmacy.com

Delivery Need By: Delivery to: ☐ Patients Home ☐ Physician's Office ☐ Other

PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name: ☐ Female ☐ Male	Prescriber Name:
Address:	Address:
City, State, Zip: , ,	City, State, Zip: , ,
Phone:	Phone:
Date of Birth:	Fax:
Social Security Number:	DEA/NPI#:

INSURANCE – PLEASE FAX COPY OF PRESCRIPTION CARD FRONT & BACK

CLINICAL INFORMATION

Diagnosis/ ICD-10 Code:	Has the patient been treated previously for this condition? ☐ Yes ☐ No
Last PPD Test M/D/Y ☐ Positive ☐ Negative Date: / /	Medications failed:
Height: feet inches Weight: lbs.	Medications on:
Allergies:	Other notes:

PRESCRIPTION INFORMATION

Medication:	Dosage/Strength:	Directions:	Quantity:	Refills:
Actemra®	☐ 162mg/0.9ml	☐ SC every OTHER week ☐ SC every week ☐ Other:	☐ 4 week supply ☐ Other:	
Cimzia®	☐ 200mg/ml Prefilled SYR ☐ Starter Kit	☐ Initial Dose: Inject 400mg SC at weeks 0,2, and 4, then: Maintenance Dose: ☐ 200mg SC every other week OR ☐ 400mg SC every 4 weeks	☐ 4 week supply	
Cosentyx ™ **Enhanced Specialty Pharmacy Program Participant*	☐ 150mg Pen ☐ 150mg Syringe	Loading Dose: ☐ 150mg 0,1,2,3,4 weeks ☐ 300mg 0,1,2,3,4 weeks Maintenance Dose: ☐ 150mg every 4 weeks ☐ 300mg every 4 weeks	☐ 4 week supply (maintenance) ☐ 5 week supply (loading) ☐ Other:	
Cosentyx ™ **Enhanced Specialty Pharmacy Program Participant* ***Covered Until You're Covered***	☐ 150mg Pen ☐ 150mg Syringe	Loading Dose: ☐ 150mg 0,1,2,3,4 weeks ☐ 300mg 0,1,2,3,4 weeks Maintenance Dose: ☐ 150mg every 4 weeks ☐ 300mg every 4 weeks	☐ 4 week supply (maintenance) ☐ 5 week supply (loading) ☐ Other:	
Enbrel®	☐ 50mg/ml Single Use Prefilled SYR ☐ 50mg/ml SureClick AutoInjector ☐ 25mg/0.5ml Prefilled SYR ☐ 25mg Vial	☐ Inject 50mg SC TWICE a week (72-96 hours apart) ☐ Inject 50mg SC ONCE a week ☐ Inject 25mg SC TWICE a week (72-96 hours apart) ☐ Other:	☐ 4 week supply ☐ Other:	
Humira®	☐ 40mg/0.8ml Pen ☐ 40mg/0.8ml Prefilled SYR ☐ 40mg/0.4ml Pen **(Citrate-Free)** ☐ 40mg/0.4ml Prefilled SYR **(Citrate-Free)**	☐ Inject 40mg SC every OTHER week ☐ Inject 40mg SC ONCE a week	☐ 4 week supply ☐ Other:	

☐ Patient is interested in patient support programs ☐ Ancillary supplies provided for administration

Physician Signature: _____ Date: _____

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Rheumatology
Enrollment Form H-Z

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PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name: ☐Female ☐Male	Prescriber Name:
Address:	Address:
City, State, Zip: , ,	City, State, Zip: , ,
Phone:	Phone:
Date of Birth:	Fax:
Social Security Number:	DEA/NPI#:

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CLINICAL INFORMATION

Diagnosis/ ICD-10 Code:	Has the patient been treated previously for this condition? ☐ Yes ☐ No
Last PPD Test M/D/Y ☐ Positive ☐ Negative Date: / /	Medications failed:
Height: feet inches Weight: lbs.	Medications on:
Allergies:	Other notes:

PRESCRIPTION INFORMATION

Medication:	Dosage/Strength:	Directions:	Quantity:	Refills:
Kineret®	☐ 100mg/0.67 ml Prefilled SYR	☐ Inject 100mg SC once daily	☐ 4 week supply ☐ Other:	
Orencia®	☐ 250mg Vial ☐ 125mg/ml SYR ☐ 125mg/ml Clickject	☐ Infuse mg at weeks 0, 2, 4 then every 4 weeks thereafter ☐ Inject 125mg once a week	☐ 4 week supply ☐ Other:	
Remicade®	☐ 100mg Vial	☐ IV mg at 0, 2, and 6 weeks (induction) ☐ IV mg every 8 weeks (maintenance) ☐ IV every weeks	☐ # of Vials	
Rituxan®	☐ 100mg/10ml Vial ☐ 500mg/50ml Vial	Specified:	☐ # of Vials	
Simponi®	☐ 100mg/1ml SmartJect AutoInjector ☐ 100mg/1ml Prefilled SYR ☐ 50mg/0.5ml SmartJect AutoInjector ☐ 50mg/0.5ml Prefilled SYR	☐ Inject 100mg SC ONCE a month ☐ Inject 50mg SC ONCE a month	☐ 4 week supply ☐ Other:	
Taltz ®	☐ 80mg/ml single-dose Prefilled Autoinjector ☐ 80mg/ml single-dose Prefilled SYR	☐ Inject 160mg SC at week 0 followed by 80mg every 4 weeks ☐ Inject 80mg SC every 4 weeks	☐ 2 syringes/pens ☐ 1 syringe/pen	
Xeljanz ®	☐ 5mg tablet	☐ Twice Daily	☐ 4 week supply	
Xeljanz XR ®	☐ 11mg tablet	☐ Take one tablet once a day	☐ 4 week supply	

☐ Patient is interested in patient support programs

☐ Ancillary supplies provided for administration

Physician Signature: _____ Date: _____

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