Prescription & Enrollment Form
Rheumatology

(800) 962-6339 Office
(866) 755-6339 Fax

Patient Information

Last Name	First Name
Social Security #	Date of Birth
Parent or Guardian	
Home Phone	Other Contact Phone
Home Address	
City, State, Zip	

Insured Information

Primary Insurance (Fax copy of card - both sides)	
Subscriber's Name	Relationship to Patient
Policy #	Group #
Primary Insurance Phone	
Prescription Card (Fax copy of card - both sides)	
Secondary Insurance	Policy #

DIAGNOSIS/MEDICAL INFORMATION (Please specify primary and secondary diagnoses)

☐ 696.0 Psoriatic Arthritis	☐ 714.30 Juvenile Rheumatoid Arthritis
☐ 714.0 Rheumatoid Arthritis	☐ 720.0 Ankylosing Spondylitis
☐ Other, Specify	Allergies:
Date of diagnosis:	
New to therapy: ☐ yes ☐ no If no, date therapy began	
TB Test Results: ☐ Negative ☐ Positive Date	Methotrexate failure or contraindication: ☐ yes ☐ no
Does patient have CHF: ☐ yes ☐ no	Ht. Wt.
Is the patient also receiving any of the following: ☐ Enbrel ☐ Humira ☐ Kineret ☐ Orencia ☐ Remicade	
Other current medications:	

PRESCRIPTION INFORMATION

Medication	Dose	Frequency	Quantity	Refills
☐ Cimzia® (Certolizumab Pegol)				
☐ Enbrel® (Etanercept)				
☐ Humira® (Adalimumab)				
☐ Kineret® (Anakinra)				
☐ Orencia® (Abatacept)				
☐ Remicade® (Infliximab)				
☐ Simponi™ (Abatacept)				
☐ Other				

SUPPLIES NEEDED (if medication is to be administered in the patient's home):

If checked, please specify the size and type (if applicable):

☐ Syringes/Needles ☐ Swabs ☐ Sharps Container ☐ Other

DELIVERY INSTRUCTIONS

☐ Physician's Office ☐ Patient's Home ☐ Other	Date Medication Needed:

Physician's Name (Please Print)

Physician's Address

Physician's Signature Date

Phone Fax

Physician's DEA#

Dr.'s Office Contact Name

License # NPI

Fax completed form to Medex BioCare (866) 755-6339

updated 10-19-09