briovaRx®

Fax:
Phone:

Rheumatology Enrollment Form

PATIENT INFORMATION

Please complete the following or ***send patient demographic sheet***

Patient Name _____
Address _____
Address 2 _____
City, State, Zip _____
Home Phone _____ Alternate Phone _____
DOB _____ Last Four of SS# _____ Gender _____
Language Preference: ☐ English ☐ Spanish ☐ Other _____

PRESCRIBER INFORMATION

Prescriber's Name _____
DEA _____
NPI _____
Group/Hospital _____
Address _____
City, State, ZIP _____
Phone _____ Fax _____
Contact Person _____ Phone _____

INSURANCE INFORMATION *(Must fax a copy of patient's insurance card including both sides)*

Prior Authorization Reference number:

MEDICAL INFORMATION (Section must be completed to process prescription) (Attach separate sheet if needed)

Diagnosis — *Please include diagnosis name with ICD-10 code*

☐ M06.9 Rheumatoid arthritis, unspecified
☐ M08.00 Unspecified juvenile rheumatoid arthritis of unspecified site
☐ M08.3 Juvenile rheumatoid polyarthritis (seronegative)
☐ M45.9 Ankylosing spondylitis of unspecified sites in spine
☐ L40.59 Other Psoriatic Anthropathy
☐ Other Diagnosis: ICD-10 Code _____ Description _____
Date of diagnosis _____
Has a TB test been performed? ☐ Yes ☐ No
Does the patient have an active infection? ☐ Yes ☐ No
Start Date _____ **Review Date** _____

Additional Information

Therapy: ☐ New ☐ Reauthorization ☐ Restart

Weight _____kg/lbs Height _____cm/in
Allergies _____
Lab Data _____
Prior Therapies _____
Concomitant Medications _____
Additional Comments _____
Injection Training Required: ☐ Yes ☐ No

PRESCRIPTION INFORMATION

Medication	Dose/Strength		Directions	Qty	Refills
☐ Actemra	☐ 80 mg/4 mL Vial ☐ 162 mg/0.9 mL Prefilled Syringe	☐ 200 mg/10 mL Vial ☐ 400 mg/20 mL Vial			
☐ Benlysta	☐ 120 mg Vial ☐ 400 mg Vial	☐ 200 mg/mL Autoinjector ☐ 200 mg/mL Prefilled Syringe			
☐ Cimzia	☐ 200 mg/mL Vial Kit ☐ 200 mg/mL Starter Kit	☐ 200 mg/mL Prefilled Syringe			
☐ Cosentyx	☐ 150 mg/mL Prefilled Pen ☐ 150 mg/mL (300 mg dose) Prefilled Pen	☐ 150 mg/mL Prefilled Syringe ☐ 150 mg/mL (300 mg dose) Prefilled Syringe			
☐ Enbrel	☐ 50 mg/mL SureClick Autoinjector ☐ 50 mg/mL Prefilled Syringe ☐ Enbrel Mini 50 mg/mL Cartridge	☐ 25 mg/0.5 mL Prefilled Syringe ☐ 25 mg Vial			
☐ Humira	☐ 10 mg/0.2 mL Prefilled Syringe ☐ 10 mg/0.1 mL Prefilled Syringe (citrate-free) ☐ 20 mg/0.4 mL Prefilled Syringe ☐ 20 mg/0.2 mL Prefilled Syringe (citrate-free)	☐ 40 mg/0.8 mL Prefilled Syringe ☐ 40 mg/0.4 mL Prefilled Syringe (citrate-free) ☐ 40 mg/0.8 mL Pen ☐ 40 mg/0.4 mL Pen (citrate-free)			
☐ Inflectra	☐ 100 mg Vial				
☐ Kevzara	☐ 150 mg/1.14 mL Prefilled Pen ☐ 200 mg/1.14 mL Prefilled Pen	☐ 150 mg/1.14 mL Prefilled Syringe ☐ 200 mg/1.14 mL Prefilled Syringe			
☐ Olumiant	☐ 2 mg Tablet				
☐ Orencia	☐ 250 mg Vial ☐ 125 mg/mL Prefilled Syringe ☐ 125 mg/mL ClickJect Autoinjector	☐ 87.5 mg/0.7 mL Prefilled Syringe ☐ 50 mg/0.4 mL Prefilled Syringe			
☐ Otezla	☐ 30 mg Tablet ☐ Starter Pack (28-day)	☐ Starter Pack (2-week)			
☐ Remicade	☐ 100 mg Vial				
☐ Renflexis	☐ 100 mg Vial				
☐ Rituxan	☐ 100 mg/10 mL Vial	☐ 500 mg/50 mL Vial			
☐ Simponi	☐ 50 mg/0.5 mL Prefilled Syringe ☐ 50 mg/0.5 mL SmartJect Autoinjector	☐ 100 mg/mL Prefilled Syringe ☐ 100 mg/mL SmartJect Autoinjector			
☐ Simponi Aria	☐ 50 mg/4 mL Vial				
☐ Stelara	☐ 45 mg/0.5 mL Vial ☐ 45 mg/0.5 mL Prefilled Syringe	☐ 90 mg/mL Prefilled Syringe			
☐ Taltz	☐ 80 mg/mL Autoinjector	☐ 80 mg/mL Prefilled Syringe			
☐ Xeljanz	☐ 5 mg Tablet				
☐ Xeljanz XR	☐ 11 mg Extended-Release Tablet				
☐ Other					

Ship to: ☐ Patient ☐ Office ☐ Other _____ Date _____ Needs by Date _____

Prescriber Authorization: I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

☐ Product Substitution permitted ☐ Dispense as Written

Prescriber's Signature: _____ Date: _____

CONFIDENTIALITY STATEMENT: This communication is intended for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential, and exempt from disclosure under applicable law. If the reader of this communication is not the intended recipient or the employee or agent responsible for delivery of the communication, you are hereby notified that any dissemination, distribution, or copying of the communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone.