

**Rheumatology  
Enrollment  
Form**



**Pharmacy Phone: 866-778-8255**  
**Pharmacy Fax: 800-432-6614**  
**intake@skyemed.com**

**Deliver Medications To:** ☐ Patient's Home ☐ Doctor's Office Date Needed By: \_\_\_\_\_

**Patient Demographics**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ SSN: \_\_\_\_\_

**Prescription Insurance: (PLEASE ATTACH A COPY OF THE FRONT AND BACK OF THE PATIENT'S CARD)**

Primary Prescription Insurance: \_\_\_\_\_ RX BIN #: \_\_\_\_\_ RX PCN#: \_\_\_\_\_  
Patient ID/Policy Number: \_\_\_\_\_ Patient RX Group Number: \_\_\_\_\_  
Secondary Prescription Insurance: \_\_\_\_\_ RX BIN #: \_\_\_\_\_ RX PCN#: \_\_\_\_\_  
Patient ID/Policy Number: \_\_\_\_\_ Patient RX Group Number: \_\_\_\_\_

**Patient Clinical Information/History: (Please attach a copy of patient's recent chart notes, pathology and labs)**

Diagnosis: \_\_\_\_\_ ICD-10 Code: \_\_\_\_\_ Diagnosis Date: \_\_\_\_\_ Patient's weight (lbs): \_\_\_\_\_ Sex: M F  
Negative TB Test: Y N Date: \_\_\_\_\_ Has HepB been ruled out/treatment initiated: Y N Pregnant: Y N  
Previous/Failed Medications: \_\_\_\_\_ Date and Duration of Therapy: \_\_\_\_\_ Reason for Discontinuation: \_\_\_\_\_

Drug Allergies: \_\_\_\_\_ ☐ NKDA  
Current Medications including OTC products: \_\_\_\_\_

**Nursing Orders**

☐ Infusion Nursing: Nurse to administer drug therapy to patient ☐ Nurse Teach & Train ☐ Other: \_\_\_\_\_

**Prescription Information**

**Actemra** ☐ 80mg/4mL ☐ 200mg/10mL ☐ 400mg/20mL  
☐ Induction Dose: Infuse 4mg/kg IV every 4 weeks  
☐ Maintenance Dose: Infuse 8mg/kg IV every 4 weeks  
**ACTEMRA 162mg PFS** \_\_\_\_\_mg/kg  
☐ Pt<100kg Inject 162mg SQ every other week  
☐ Pt>100kg Inject 162mg SQ every week  
Quantity: 28 days supply Refills: \_\_\_\_\_

**Cimzia 200mg** ☐ PFS ☐ VIAL ☐ LYO POWDER\*  
☐ Induction Dose: Inject 400mg SQ at weeks 0, 2 & 4  
☐ Maintenance Dose: Inject 200mg SQ every other week  
☐ Other Dose: Inject 400mg SQ every 4 weeks  
*\*Lyophilized powder to be administered by healthcare professionals only*  
Quantity: \_\_\_\_\_ Refills: \_\_\_\_\_

**Enbrel** ☐ 50mg/mL Sureclick ☐ 50mg/mL PFS ☐ 25mg/0.5mL PFS  
☐ Inject 50mg SQ Once a week  
☐ Inject 25mg SQ TWICE a week  
Quantity: 28 days supply Refills: \_\_\_\_\_

**Humira** ☐ 40mg/0.8mL Pen ☐ 40mg/0.8mL PFS ☐ 20mg/0.4mL PFS  
☐ Inject 40mg SQ every OTHER week  
☐ Inject 20mg SQ every OTHER week  
Quantity: 30 days supply Refills: \_\_\_\_\_

**Xeljanz 5mg Tab** ☐ Take One Tab by mouth Twice a day  
Quantity: \_\_\_\_\_ Refills: \_\_\_\_\_

**Prescriber Information:**

**Prescriber Name:** \_\_\_\_\_ **Facility Group or Hospital:** \_\_\_\_\_  
**Street Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_  
**Office Phone:** \_\_\_\_\_ **Office Fax:** \_\_\_\_\_ **Office Contact:** \_\_\_\_\_  
**DEA:** \_\_\_\_\_ **NPI:** \_\_\_\_\_ **UPIN:** \_\_\_\_\_ **State License:** \_\_\_\_\_  
**Physician Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Orencia** ☐ 250mg Vial ☐ 125mg/mL PFS  
☐ Infuse \_\_\_\_\_mg in 100mL of 0.9% NaCl at weeks 0, 2 & 4 then every 4 weeks thereafter  
☐ Inject 1 Syringe SQ per week 8  
Quantity: 28 days supply Refills: \_\_\_\_\_

**Remicade 100mg** \_\_\_\_\_mg/kg  
☐ Induction Dose: Infuse IV in 250mL of 0.9% NaCl at 0, 2 & 6 weeks  
☐ Maintenance Dose: Infuse IV in 250mL of 0.9% NaCl every 8 weeks  
☐ Maintenance Dose: Infuse IV in 250mL of NaCl every 6 weeks  
Quantity: \_\_\_\_\_ Refills: \_\_\_\_\_

**Rituxan** ☐ 100mg/10mL vial ☐ 500mg/50mL vial  
Infuse 2 doses of 1000mg in 1 liter of 0.9% NCl separated by 2 weeks  
Quantity: 28 days supply Refills: \_\_\_\_\_

**Simponi** ☐ 50mg/0.5mL Smartject ☐ 50mg/0.5mL PFS  
Inject 50mg (0.5mL) SQ Once a month  
**Simponi Aria** ☐ 50mg/4mL SDV  
Infuse 2mg/kg in 100mg NS IV over 30mins at weeks 0 & 4, then Q 8 weeks  
Quantity: 28 days supply Refills: \_\_\_\_\_

**Stelara** ☐ 45mg PFS ☐ 90mg PFS  
☐ Inject 45mg SQ at weeks 0, 4 & then every 12 weeks  
☐ Inject 90mg SQ at weeks 0, 4 & then every 12 weeks ▲  
Quantity: 30 days supply Refills: \_\_\_\_\_

**Otezla** ☐ Take 10mg PO QD Day 1, and increasing by 10mg daily until taking 30mg BID thereafter  
Quantity: \_\_\_\_\_ Refills: \_\_\_\_\_