MedBox
844.840.1758 | 844.840.1759 |
contact@medboxrx.com | www.medboxrx.com

RHEUMATOLOGY ENROLLMENT FORM MEDICATIONS A-I

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 Prefilled syringe ☐ 80 mg/4ml Vial ☐ 200mg/10ml Vial ☐ 400mg/20ml Vial	☐ SC every OTHER week SC ☐ every week ☐ Induction dose: 4mg/kg (_____mg dose) every 4 weeks. ☐ Maintenance dose: 8mg/kg (_____mg dose) every 4 weeks.	☐ 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 ☐ Syringes	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:	
Inflectra ®	☐ 100 MG VIAL	☐ Induction Dose: 5mg/kg (Dose _____mg) IV at 0, 2 and 6 weeks, then every 8 weeks thereafter ☐ Maintenance Dose: 5mg/kg (Dose _____mg) IV every 8 weeks ☐ Other_____		

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

Office Contact Name: _____ Preferred Phone Number & Extension: _____

Physician Signature: _____ Date: _____

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By signing below, I hereby authorize MedBox Specialty pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.

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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:
Kevzara®	☐ 150mg/1.14ml Prefilled SYR ☐ 150mg/1.14ml Prefilled Pen ☐ 200mg/1.14ml Prefilled SYR ☐ 200mg/1.14ml Prefilled Pen	☐ Inject once every TWO weeks	☐ 4 week supply	
Kineret®	☐ 100mg/0.67 ml Prefilled SYR	☐ Inject 100mg SC once daily	☐ 4 week supply ☐ Other:	
Olumniant	☐ 2 mg tabs	☐ Take 2 mg by mouth once daily	☐ tabs	
Orencia®	☐ 250mg Vial ☐ 125mg/ml SYR ☐ 125mg/ml Clickject ☐ 50 mg SYRINGE (for children ≥ 2years and weighing 10kg to less than 25kg	☐ IV dosage: Infuse mg at weeks 0, 2, 4 then every 4 weeks ☐ thereafter Subcutaneous dosage: Inject 125mg SC once a week	☐ 4 week supply ☐ Other:	
Otezla®	☐ Starter Kit ☐ 30 mg	Starter Kit: Maintenance Dose: ☐ Take as directed ☐ Twice Daily	☐ 4 week supply	
Remicade®	☐ 100mg Vial	☐ IV mg at 0, 2, and 6 weeks (induction) ☐ IV mg every 8 weeks (maintenance) ☐ IV every weeks	☐ # of Vials	
Renflexis™	☐ 100mg Vial	☐ Induction Dose: 5mg/kg (Dose _____mg) IV at 0, 2 and 6 weeks, then every 8 weeks thereafter ☐ Maintenance Dose: 5mg/kg (Dose _____mg) IV every 8 weeks ☐ Other_____	☐ # 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

Office Contact Name: _____ Preferred Phone Number & Extension: _____

Physician Signature: _____ Date: _____

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