RHEUMATOLOGY **ENROLLMENT FORM**

GREENHILL PLUS+ Specialty Pharmacy Solution

Connection • Care • Community

PLEASE FAX: FOURTH STREET - 302-502-3885 • MARKET STREET - 302-513-9396

Greenhill Pharmacy | 2511 W 4th St, Wilmington, DE 19805

Patient Information

Please complete the following or send patient demographic sheet

Patient Name _____

DOB _____ Last Four of SS# _____ Gender: ◯M ◯F

Language Pref: ◯ English ◯ Spanish ◯ Other _____

Home Address _____

Home Address 2 _____

City _____ State _____ Zip _____

Shipping Address (If different from above) _____

Home Phone _____ Work Phone _____

Prescriber Information

Prescriber's Name _____

DEA# _____

NPI# _____

Group/Hospital _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____

Contact Person _____ Phone _____

Medical Information: Section must be completed to process prescription. (Attach separate sheets as 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

Drugs	Direction	Quantity	Refills
Actemra® (tocilizumab) ◯ PFS ◯ Vials	◯ Inject 162 mg subcut every week ◯ Inject 400 mg subcut every 4 weeks	◯ 4 x 162 mg/0.9mL ◯ 2x100 mg/ml	
Cimzia® (certolizumab) ◯ PFS ◯ Vials	◯ Inject 400 mg subcut at weeks 0, 2 and 4 ◯ Inject 200 mg subcut every 2 weeks ◯ Inject 400 mg subcut every 4 weeks	◯ 6 x 200 mg/mL ◯ 2 x 200 mg/mL	
Cosentyx® (secukinumab) ◯ Sensoready® Pen ◯ PFS	◯ Inject 150 mg subcut once weekly at weeks 0, 1, 2 and 3 ◯ Inject 300 mg subcut once weekly at weeks 0, 1, 2 and 3 ◯ Inject 150 mg subcut on week 4 and every 4 weeks thereafter ◯ Inject 300 mg subcut on week 4 and every 4 weeks thereafter	◯ 4 x 150 mg/mL ◯ 8 X 150 mg/mL	
Enbrel® (etanercept) ◯ SureClick® Autoinjector ◯ PFS ◯ Vials	◯ Inject 50 mg subcut every week ◯ Inject _____ mg (0.8 mg/kg x _____ kg) subcut every week	◯ 4 x 50 mg/mL ◯ ____ x 25 mg/mL	
Humira® (adalimumab) *Adults & Pediatrics Age ≥ 2 years* ◯ Pens ◯ PFS	◯ Inject 10 mg subcut every other week (10 to <15 kg) ◯ Inject 20 mg subcut every other week (15 to <30 kg) ◯ Inject 40 mg subcut every other week (≥30 kg) ◯ Inject 40 mg subcut once weekly	◯ 2 x 10 mg/0.2mL ◯ 2 x 20 mg/0.4mL ◯ 2 x 40 mg/0.8mL ◯ 4 x 40 mg/0.8mL	
Kevzara® (sarilumab) ◯ PFS	◯ Inject 150 mg subcut every other week ◯ Inject 200 mg subcut every other week	◯ 2 x 150 mg/1.14mL ◯ 2 x 200 mg/1.14mL	

Drugs	Direction	Quantity	Refills
Orencia® (abatacept) ◯ Vials ◯ PFS ◯ ClickJect™	◯ Infuse ____ mg at week 0 only ◯ Infuse ____ mg at weeks 0 and 2 *(JIA <75 kg: 10 mg/kg; JIA ≥75 kg or RA:<60 kg: 500 mg, 60-100 kg: 750 mg; >100 kg: 1000 mg)* ◯ Infuse ____ mg at week 4 and every 4 weeks thereafter *(JIA <75 kg: 10 mg/kg; JIA ≥75 kg or RA:<60 kg: 500 mg, 60-100 kg: 750 mg; >100 kg: 1000 mg)* ◯ Inject 125 mg subcut once weekly	◯ ____ x 250 mg ◯ 4 x 125 mg/mL	
Otezla® (apremilast) ◯ 28-day starter pack	◯ Take as directed per package instructions ◯ Take 30 mg by mouth twice daily	◯ 55 tablets ◯ 60 x 30 mg tablets	
Simponi® (golimumab) ◯ SmartJect® Autoinjector ◯ PFS	◯ Inject 50 mg subcut once a month	◯ 1 x 50 mg/0.5mL	
Simponi Aria® (golimumab) ◯ Vials	◯ Infuse ____ mg (2 mg/kg x ____ kg) over 30 minutes at weeks 0 ◯ Infuse ____ mg (2 mg/kg x ____ kg) over 30 minutes at week 4 and every 8 weeks thereafter	◯ ____ x 50 mg/4ml	
Stelara® (ustekinumab) ◯ PFS	◯ Inject 45 mg subcut on Day 1 (≤100 kg) ◯ Inject 90 mg subcut on Day 1 (>100 kg) ◯ Patient eligible for self-administration: ◯ Yes ◯ No _____	◯ 1 x 45 mg/0.5mL ◯ 1 x 90 mg/mL	
Xeljanz® (tofacitinib)	◯ Take 5 mg by mouth twice daily ◯ _____	◯ 60 x 5 mg tablets _____	
Xeljanz® XR (tofacitinib)	◯ Take 11 mg by mouth once daily	◯ 30 x 11 mg tablets	

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.

Prescriber's Signature: _____ _____ ***Date:*** _____

PRODUCT SUBSTITUTION PERMITTED DISPENSE AS WRITTEN

Supervising Physician / Supervising Physician Signature: _____

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NEW REFERRAL CHECKLIST
PLEASE USE THIS CHECKLIST FOR PATIENTS WITH RHEUMATOID ARTHRITIS

Please use the attached checklist as a reference in order to provide the proper documentation to process the required prior authorization for your patient's treatment. All lab reports (or EMR) must contain the following information within the last 30 days. ***Please forward any updates to us you receive from the insurance company regarding approvals or denials.***

REQUIRED INFORMATION:

- ☐ Patient name
- ☐ Patient Demographics (Address, Phone Number, DOB, etc.)
- ☐ Medication list and allergies
- ☐ Insurance information with prescription insurance. Please include a copy of card.
  If only medical insurance card is provided, please include local pharmacy information.
- ☐ MD name/NPI/Office contact/Phone number
- ☐ Drug indicated with refills
- ☐ MD signature and date on referral form
- ☐ Recent TB test results and date
- ☐ Previous treatment
- ☐ Symptoms
- ☐ Clinical notes

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