

Rheumatology Enrollment Form O-Z

2502 U.S. Highway 9. Howell, N. J. 07731 Lwww.**parkwaysp.**com | Fmail: intake@parkwaysp.com | Phone: 1-866-355-7797 | Fax: 1-888-551-6289

Name:				INFORMATION	O Male O Female	O Malo O Fomalo	
Address:			City:			Zip:	
Phone:			City: State: Alt Phone:			Email:	
SS #:			Primary Langi				
33 #.				R INFORMATION	Emergency Contact.	Emergency Contact:	
Due a suilaire a Due atiti			PRESCRIBE	RINFORMATION	NDI#		
Prescribing Practition Supervising Physic					NPI#: NPI#:		
Address:		Cit	y: Sta	te: Zip:	Tax ID:		
Phone:		Fa	·		Office Contact:		
				ON INFORMATION			
Needs by Date:		Ship to:		O Prescriber 1st ord	der only O Prescriber all orders O Other		
Drug	Dose		& Quantities			Refills	
O Olumiant O Orencia®	2mg Tablets	(mg once daily (Qty:	30)			
	O Vials	i i	:NOUS (IV): .: Infuse mg :	via IV on week 0, 2, a	and 4 (Qty:)		
	O Pre-filled Syringe		ENANCE: Infuse	4 weeks (Qty:)			
	O ClickJect™		ANEOUS (SQ): 25mg SQ once week	ch (Otra 4)			
	O 28 Day Starter Pack			ge instructions. (Qty:	55)		
O Otezla®	O Maintenance	O Take 3	0 ma PO twice daily	(Qtv: 60)			
				(Qty: 30). Renal Dosin			
O Inflectra O Remicade O Renflexis	O 100 mg Vial	(6 NaCL at weeks 0, 2,	•		
	O mg/kg		O MAINTENANCE: IV in 250ml of 0.9% NaCL every 8 weeks O MAINTENANCE: IV in 250ml of 0.9% NaCL every 6 weeks				
		O Other:					
O Rinvoq	15mg Tablet		mg once daily (Qty:	<i>i</i>			
O Rituxan	O 500mg/ 50 mL Vials	O Infuse	1000mg via IV on we	ek 0 and week 2. Re	peat every months thereafter (Qty: 2 doses	s)	
O Simponi®	O SmartJect® (Pen) O Pre-filled Syringe	O Inject 5	O Inject 50 mg SQ once a month (Qty: 1)				
O Simponi® Aria™	O 50mg Vials		O INITIAL: Infuse 2 mg/kg over 30 min at weeks 0 and 4 (Qty: 2 doses) Qty vials O MAINTENANCE: Infuse 2 mg/kg over 30 min every 8 weeks thereafter (Qty: 1 dose) Qty vials				
O Xeljanz®	5 mg Tablets		mg PO twice daily (0				
O Xeljanz® XR	11 mg Tablets	O Take 11	mg PO once daily (0	aty: 30) INFORMATION			
** PLEAS	SE FAX COPY OF PRESCRIP	TION MEDICAT			AS WELL AS ANY CLINICAL NOTES REGARDING	THERAPY **	
PREVIOUS THERA	PIES:	Tried & Faile	d (Duration):	Not Tolerated:	Contraindication:		
O Methotrexate		0 ()	0			
O Plaquenil		0 ()	0			
O Sulfasalazine O (_		0 ()	0			
O Meloxicam O (_		0 ()	0			
O Naproxen / Aleve O (0 ()	0			
O Tramadol		0 ()	0			
O Enbrel		0 ()	0			
O Humira		0 ()	0			
O Cimzia		0 ()	0			
O H20.9 Unspecifie	•			, , , , ,	pecified Acute and Subacute		
	oid Arthritis, Unspecified				Rheumatoid Factor, Unspecified		
O M31.6 Other Giar					thout Rheumatoid Factor, Unspecified		
-	g Spondylitis, Unspecified Arteritis with Polymyalgia RI	neumatica	O M08.00 Un O Other:	ispecified Juvenile Rh	neumatoid Arthritis of Unspecified Site		
Date of Diagnosis:		_ Allergies:	Llan Dunda	1 t t	- ON- Date: / /		
	out: O Yes O No Date: _			l out/treated: O Yes	SONO Date:		
Patient Height: Additional Clinical I	Information:	Weight:		kg/lbs			
adond. Onnedi			INJECT	ION TRAINING			
O Patient has recei	ved pen and injection traini	ng O Physici	an's office to provide		O Parkway Pharmacy to coordinate injection tra	aining	
_	ctitionerBy signing this form	_	ır services, you are a	lso authorizing Parkw	vay Pharmacy to serve as your prior authorization of	designated agent in	
		. ,					
Prescribing Practi	tioner:		CONFIDEN	NTIALITY NOTICE	Date		
			CONFIDE	THACH I NOTICE			

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