



Rheumatology Enrollment Form O-Z

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PATIENT INFORMATION

Name, Date of Birth, Address, City, State, Zip, Phone, Alt Phone, Email, SS #, Primary Language, Emergency Contact

PRESCRIBER INFORMATION

Prescribing Practitioner, Supervising Physician, Address, City, State, Zip, Phone, Fax, NPI#, Tax ID, Office Contact

PRESCRIPTION INFORMATION

Needs by Date, Ship to, Drug, Dose, Direction & Quantities, Refills. Includes sections for O Olumiant, O Orencia, O Otezla, O Inflectra, O Remicade, O Renflexis, O Rinvoq, O Rituxan, O Simponi, O Simponi Aria, O Xeljanz, O Xeljanz XR.

MEDICAL INFORMATION

** PLEASE FAX COPY OF PRESCRIPTION MEDICATION/MEDICAL CARD, FRONT AND BACK, AS WELL AS ANY CLINICAL NOTES REGARDING THERAPY **

PREVIOUS THERAPIES: Tried & Failed (Duration), Not Tolerated, Contraindication. Lists various medications like Methotrexate, Plaquenil, Sulfasalazine, etc.

Diagnosis and Allergies section with checkboxes for H20.9 Iridocyclitis, M06.9 Rheumatoid Arthritis, etc.

Date of Diagnosis, Allergies, Active TB ruled out, Hep B ruled out/treated, Patient Height, Weight, Additional Clinical Information.

INJECTION TRAINING

O Patient has received pen and injection training O Physician's office to provide injection training O Parkway Pharmacy to coordinate injection training

PRESCRIBING PRACTITIONER SIGNATURE

To Prescribing Practitioner: By signing this form and utilizing our services, you are also authorizing Parkway Pharmacy to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies, and co-pay assistance foundations.

Prescribing Practitioner: _____ Date _____

CONFIDENTIALITY NOTICE

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