

RHEUMATOLOGY ENROLLMENT FORM

EMAIL: INFO@BRIGENT.COM
FAX: 818-963-7526
PHONE: 818-963-7525

Brigent Specialty Pharmacy
4766 Park Granada Suite 112,
Calabasas, CA 91302
NPI: 1588300545



Ship to: Patient Physician Other

PATIENT INFORMATION

Patient Name (Last, First): _____ DOB: _____ Gender: Female Male
 Address: _____ City/State/Zip: _____
 SSN: _____ Allergies: _____
 Phone: _____ Alt Phone: _____
 Email: _____ Preferred Contact: Phone Email
 Parent/Caregiver/Legal Guardian Name (Last, First): _____
 Relationship to Patient: _____ Phone: _____

INSURANCE INFORMATION: Please fax copy of prescription and insurance cards with this form (front and back)

CLINICAL INFORMATION

Diagnosis (ICD-10): Date of Dx: _____
 M06.9 Rheumatoid Arthritis, unspecified M45.9 Ankylosing Spondylitis of unspecified sites in spine
 M08.00 Unspecified Juvenile RA of unspecified site L40.52 Psoriatic Arthritis
 L40.59 Other Psoriatic Arthropathy Other Code: _____ Description: _____
 BSA: _____ Weight: _____ lb/kg Height: _____ in/cm **Treatment status:** New to therapy Continuation of
 TB Result: _____ Date: _____ therapy date of last treatment ____/____/____
 Needs by: ____/____/____

Tried and Failed History:

Medication: _____ Duration: _____
 Response: Intolerant Ineffective Contraindicated Side Effects Other: _____

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QTY	REFILLS
<input type="checkbox"/> Actemra	<input type="checkbox"/> 162mg/0.9ml Pen <input type="checkbox"/> 162mg/0.9ml PFS	For patient weighing <100kg <input type="checkbox"/> Inject 162mg SQ every other week	2	____
		For patient weighing ≥100kg <input type="checkbox"/> Inject 162mg SQ weekly	4	____
<input type="checkbox"/> Cimzia	<input type="checkbox"/> 200mg/1ml Starter Kit <input type="checkbox"/> 200mg/1ml PFS	<input type="checkbox"/> Initial Dose: Inject 400mg SQ initially, then repeat dose at week 2 and 4	6 PFS	None
		<input type="checkbox"/> Maintenance: Inject 400mg SQ every 4 weeks	2 PFS	____
<input type="checkbox"/> Cosentyx	<input type="checkbox"/> 150mg/ml PFS <input type="checkbox"/> 150mg/ml Sensoready Pen <input type="checkbox"/> 150mg/ml (2 pack) PFS <input type="checkbox"/> 150mg/ml (2-pen pack) Sensoready Pen <input type="checkbox"/> 300mg/2ml PFS <input type="checkbox"/> 300mg/2ml UnoReady Pen	<input type="checkbox"/> Initial Dose: Inject <input type="checkbox"/> 150mg or <input type="checkbox"/> 300mg SQ weekly at week 0, 1, 2, 3, and 4	5 week supply	None
		<input type="checkbox"/> Maintenance: Inject <input type="checkbox"/> 150mg or <input type="checkbox"/> 300mg SQ every 4 weeks	4 week supply	____
<input type="checkbox"/> Enbrel	<input type="checkbox"/> 50mg/ml Enbrel Mini-Cartridge <input type="checkbox"/> 50mg/ml PFS <input type="checkbox"/> 50mg/ml SureClick Autoinjector	<input type="checkbox"/> Inject 50mg SQ weekly	4	____
<input type="checkbox"/> Humira	<input type="checkbox"/> Citrate Free 40mg/0.4ml Pen <input type="checkbox"/> Citrate Free 40mg/0.4ml PFS	<input type="checkbox"/> Inject 40mg SQ every other week	2	____
		<input type="checkbox"/> Alternate Dose: Inject 40mg SQ every week	4	____
		<input type="checkbox"/> Citrate Free 80mg/0.8ml Pen: Inject 80mg SQ every other week	2	____

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MEDICATION	STRENGTH	DOSE & DIRECTIONS	QTY	REFILLS
<input type="checkbox"/> Otezla	<input type="checkbox"/> Titration Starter Pack (28 days) <input type="checkbox"/> 30mg Tablet	<input type="checkbox"/> Initial Titration Dose: Take as directed per package instructions	1 starter pack	None
		<input type="checkbox"/> Maintenance: Take 30mg by mouth twice daily	30 tabs	___
<input type="checkbox"/> Rinvoq	<input type="checkbox"/> 15mg ER tablet	<input type="checkbox"/> Take 1 tablet by mouth every day	30 tabs	___
<input type="checkbox"/> Simponi	<input type="checkbox"/> 50mg/0.5ml SmartJect Autoinjector <input type="checkbox"/> 50mg/0.5ml PFS	<input type="checkbox"/> Inject 50mg SQ once per month	1	___
		<input type="checkbox"/> Initial Dose: Inject 2mg/kg IV at weeks 0 and 4	2 doses	None
	<input type="checkbox"/> Simponi Aria 50mg/4ml single use vial	<input type="checkbox"/> Maintenance Dose: Inject 2mg/kg IV every 8 weeks thereafter	___	___
<input type="checkbox"/> Stelara	<input type="checkbox"/> 45mg/0.5ml PFS <input type="checkbox"/> 90mg/ml PFS	<input type="checkbox"/> Initial Dose: Inject <input type="checkbox"/> 45mg or <input type="checkbox"/> 90mg SQ initially and 4 weeks later, followed by every 12 weeks	2	None
		<input type="checkbox"/> Maintenance Dose: Inject <input type="checkbox"/> 45mg or <input type="checkbox"/> 90mg SQ every 12 weeks	1	___
<input type="checkbox"/> Tremfya	<input type="checkbox"/> 100mg/ml Single-Dose PFS <input type="checkbox"/> 100mg/ml Autoinjector	<input type="checkbox"/> Initial Dose: Inject 100mg SQ at week 0 and on week 4	1	1
		<input type="checkbox"/> Maintenance: Inject 100mg SQ every 8 weeks	1	___
<input type="checkbox"/> Xeljanz	<input type="checkbox"/> 5mg tablet	<input type="checkbox"/> Take 1 tablet by mouth twice daily	60 tabs	___
<input type="checkbox"/> Xeljanz XR	<input type="checkbox"/> 11mg tablet	<input type="checkbox"/> Take 1 tablet by mouth every day	30 tabs	___
<input type="checkbox"/> Other: _____		<input type="checkbox"/> _____	___	___

PRESCRIBER INFORMATION

Prescriber Name: _____ NPI: _____ DEA: _____ LIC#: _____
 Address: _____
 City: _____ Zip: _____ Phone: _____ Fax: _____
 Contact Person: _____ Contact Phone: _____

PRESCRIBER SIGNATURE (DO NOT STAMP) NY & IA prescriptions must be submitted via e-script

"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute

May Substitute / Product Selection Permitted / Substitution Permissible

Prescriber's Signature: _____

Prescriber's Signature: _____

Date: _____

Date: _____

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing above, I hereby authorize Brigent 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 requests as my signature.