RHEUMATOLOGY ENROLLMENT FORM

EMAIL: INFO@BRIGENT.COM
FAX: 818-963-7526
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IVI Pharmacy, Inc dba
Brigent Specialty Pharmacy
4766 Park Granada Suite 112,
Calabasas, CA 91302
NPI: 1588300545

BRIGENT SPECIALTY PHARMACY

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
☐ M08.00 Unspecified Juvenile RA of unspecified site
☐ L40.59 Other Psoriatic Arthropathy)
BSA: _____Weight: _____ lb/kg Height: _____ in/cm
TB Result: _____ Date: _____

☐ M45.9 Ankylosing Spondylitis of unspecified sites in spine
☐ L40.52 Psoriatic Arthritis
☐ Other Code: _____ Description: _____
Treatment status: ☐ New to therapy ☐ Continuation of 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
☐ Actemra	☐ 162mg/0.9ml Pen ☐ 162mg/0.9ml PFS	**For patient weighing <100kg** ☐ Inject 162mg SQ every other week	2	____
		For patient weighing ≥100kg ☐ Inject 162mg SQ weekly	4	____
☐ Cimzia	☐ 200mg/1ml Starter Kit ☐ 200mg/1ml PFS	☐ **Initial Dose:** Inject 400mg SQ initially, then repeat dose at week 2 and 4	6 PFS	None
		☐ **Maintenance:** Inject 400mg SQ every 4 weeks	2 PFS	____
☐ Cosentyx	☐ 150mg/ml PFS ☐ 150mg/ml Sensoready Pen ☐ 150mg/ml (2 pack) PFS ☐ 150mg/ml (2-pen pack) Sensoready Pen ☐ 300mg/2ml PFS ☐ 300mg/2ml UnoReady Pen	☐ **Initial Dose:** Inject ☐ 150mg or ☐ 300mg SQ weekly at week 0, 1, 2, 3, and 4	5 week supply	None
		☐ **Maintenance:** Inject ☐ 150mg or ☐ 300mg SQ every 4 weeks	4 week supply	____
☐ Enbrel	☐ 50mg/ml Enbrel Mini-Cartridge ☐ 50mg/ml PFS ☐ 50mg/ml SureClick Autoinjector	☐ Inject 50mg SQ weekly	4	____
☐ Humira	☐ Citrate Free 40mg/0.4ml Pen ☐ Citrate Free 40mg/0.4ml PFS	☐ Inject 40mg SQ every other week	2	____
		☐ Alternate Dose: Inject 40mg SQ every week	4	____
		☐ Citrate Free 80mg/0.8ml Pen: Inject 80mg SQ every other week	2	____

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

PRESCRIBER INFORMATION

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

PRESCRIBER SIGNATURE (DO NOT STAMP)

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

Prescriber's Signature: _____
Date: _____

May Substitute / Product Selection Permitted / Substitution Permissible

Prescriber's Signature: _____
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.