DOTTIE'S PHARMACY
specialty & compounding

Rheumatoid Arthritis Medications Enrollment Form

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Date: _____ Needs by date: _____ Ship to: Patient ____ Office: ____ Other: _____

Patient Information:

Patient Name: _____
Address: _____
City, State, Zip: _____
Main Phone: _____ Alt. Phone: _____
Last 4 of SSN: _____ Height _____ ○ in ○ cm Weight _____ ○ lbs ○ kg
Date of Birth: _____ ○ Male ○ Female

Prescriber Information:

Prescriber Name: _____
DEA: _____ NPI: _____ Group: _____
Address: _____
City, State, Zip: _____
Phone: _____ Fax: _____
Contact Person: _____

INSURANCE INFORMATION: PLEASE FAX A COPY OF PRESCRIPTION CARD AND MEDICAL CARD (FRONT AND BACK)

Clinical Information: Statement of Medical Necessity

Primary Diagnosis: _____ Date of Diagnosis: _____ Allergies: _____ ○ NKDA Severity: ○ Mild ○ Moderate ○ Severe ○ Symptoms present ≥ 1 year
ICD -10 code: ○ M05.9 Rheumatoid arthritis with rheumatoid factor, unspecified ○ Other ICD-10 Code: _____
Rheumatoid positive factor: _____ Joints Affected: _____ Number of Tender Joints: _____ Number of Swollen Joints: _____
Prior Failed medications: _____ Reason for discontinuation: _____ Current Medications: _____
Renal Dysfunction: ○ Yes ○ No Current SCr: _____ CrCl: _____ mL/min Lab Values: ANC: _____ ALC: _____ Platelets: _____ Hemoglobin: _____ AST: _____ ALT: _____
Does patient have a latex allergy? ○ **Yes** ○ **No** **Has patient received TB/PPD test?** ○ **Yes** ○ **No** **PPD Test date:** ___/___/___ **Result:** _____

Prescription Information

Medication	Dose/ Strength	Directions	Quantity	Refills
Actemra ® (tocilizumab)	○ 80 mg/ 4 mL ○ 400 mg/ 20 mL ○ 200 mg/ 10 mL ○ 162 mg/ 0.9 mL Prefilled Syringe	○ IV: Infuse 4 mg/kg IV ONCE every 4 weeks (Max dose: 800mg) ○ IV: Infuse 8 mg/kg IV ONCE every 4 weeks (Max dose: 800mg) ○ SC < 100 kg: Inject 162 mg SC ONCE every **OTHER** week ○ SC < 100 kg: Inject 162 mg ONCE every week ○ SC ≥ 100 kg: Inject 162 mg SC ONCE every week		
Amjevita ™ (adalimumab-atto)	○ 40 mg/0.8 mL Pen ○ 40 mg/0.8 mL Prefilled Syringe	○ Inject 40 mg SC **EVERY OTHER** week ○ If **NOT** taking concomitant methotrexate may increase to inject 40 mg SC **EVERY** week		
Arava ® (leflunomide)	○ 10 mg Oral Tablets ○ 20 mg Oral Tablets	○ Induction: Take 100 mg PO ONCE **daily** for **3 days** (may omit if high risk for toxicity) ○ Maintenance: Take 20 mg ONCE **daily** (Max dose: 20 mg daily) ○ Maintenance: Take 10 mg ONCE **daily**		
Cimzia ® (certolizumab pegol)	○ 200 mg/mL Vial ○ Starter Kit 6 x 200 mg/mL ○ 200 mg/mL Prefilled Syringe	○ Induction: Inject 400 mg (2 x 200 mg) SC **ONCE** at weeks 0, 2, and 4 ○ Maintenance: Inject 200 mg once **EVERY OTHER** week ○ Maintenance: Inject 400 mg (2 x 200 mg) once every 4 weeks		
Duexis ® (Ibuprofen/famotidine)	○ 800 mg/ 26.6 mg Oral Tablets	○ Take one tablet **three times daily**		
Enbrel ® (etanercept)	○ 25 mg Vials ○ 50 mg/mL SureClick ○ 25 mg/0.5 mL Prefilled Syringe ○ 50 mg/mL Prefilled Syringe	○ Inject 50 mg SC ONCE weekly		
Erelzi ™ (etanercept-szzs)	○ 25 mg/0.5 mL Prefilled Syringe ○ 50 mg/mL Prefilled Syringe ○ 50 mg/mL Sensoready Pen	○ Inject 50 mg SC ONCE weekly		
○ Humira ® (adalimumab) ○ Humira® Citrate-free	○ 40 mg/0.8 mL Pen ○ 40 mg/0.8 mL Prefilled Syringe ○ 40 mg/0.4 mL Pen ○ 40 mg/0.4 mL Prefilled Syringe	○ Inject 40 mg SC **EVERY OTHER** week ○ If **NOT** taking concomitant methotrexate may increase to inject 40 mg SC **EVERY** week		
Kevzara ® (sarilumab)	○ 150 mg/ 1.14 mL Prefilled Syringe ○ 200 mg/ 1.14 mL Prefilled Syringe	**Check ANC, Platelets, ALT, AST** ○ Inject 200 mg SC ONCE every 2 weeks		
Kineret ® (anakinra)	○ 100 mg/ 0.67 mL Prefilled Syringe	○ Inject 100 mg SC ONCE daily		
Orencia ® (abatacept)	○ 125 mg/mL ClickJect ○ 250 mg Vial ○ 87.5 mg/ 0.7 mL Prefilled Syringe ○ 50 mg/ 0.4 mL Prefilled Syringe ○ 125 mg/mL Prefilled Syringe	○ IV Induction: Infuse weight based dose: _____ mg IV every 0, 2, 4 weeks [< 60 kg = 500 mg; 60-100 kg = 750 mg; > 100 kg = 1000 mg] ○ IV Maintenance: Infuse weight based dose: _____ mg IV every 4 weeks [< 60 kg = 500 mg; 60-100 kg = 750 mg; > 100 kg = 1000 mg] ○ SC Maintenance: Inject 125 mg SC once weekly (may initiate SC with or without IV induction) - With IV induction start SC injection within 24 hrs of the IV infusion		
Inflectra ™ (infliximab-dyyb)	○ 100 mg Vial Note: **MUST be used in COMBINATION with METHOTREXATE**	○ Infuse 3 mg/kg = _____ mg IV at weeks 0, 2, and 6 weeks ○ Infuse 3 mg/kg = _____ mg IV at weeks 8 weeks ○ Incomplete response: Infuse _____ mg IV every _____ weeks [up to MAX of 10 mg/kg and a dosing interval of 4-8 weeks]		
Remicade ® (infliximab)	○ 100 mg Vial Note: **MUST be used in COMBINATION with METHOTREXATE**	○ Infuse 3 mg/kg = _____ mg IV at weeks 0, 2, and 6 weeks ○ Infuse 3 mg/kg = _____ mg IV at weeks 8 weeks ○ Incomplete response: Infuse _____ mg IV every _____ weeks [up to MAX of 10 mg/kg and a dosing interval of 4-8 weeks]		
Rituxan ® (rituximab)	○ 10 mg/mL Vial **Note: MUST be used in COMBINATION with METHOTREXATE** **Glucocorticoids given prior to treatment can decrease infusion reactions**	○ Induction: Infuse 1000 mg IV on day 1 and day 15 ○ Maintenance: Repeat (1000 mg on day 1 & 15) every 24 weeks ○ Maintenance: May Repeat (1000 mg on day 1 & 15) NO SOONER than every 16 weeks		
Simponi ® (golimumab) Simponi ® Aria™ (golimumab)	○ 50 mg/ 4 mL vial Simponi Aria ○ 100 mg/ mL Autoinjector ○ 100 mg/ mL Prefilled Syringe ○ 50 mg/ 0.5 mL Autoinjector ○ 50 mg/ 0.5 mL Prefilled Syringe	○ IV Induction: Inject 2 mg/ kg = _____ mg IV at week 0, 4, and 8,weeks ○ IV Maintenance: Inject 2 mg/ kg = _____ mg IV every 8 weeks ○ SC Maintenance: Inject 50 mg SC every 4 weeks		
Xeljanz ® (tofacitinib) Xeljanz ® XR (tofacitinib)	○ 5 mg oral tablet IR ○ 11 mg oral tablet XR	**- Check absolute lymphocyte, neutrophil, and hemoglobin counts prior to initiation** ○ IR: Take 5 mg PO **TWICE DAILY** ○ XR: Take 11 mg PO **ONCE DAILY**		
Methotrexate	○ 2.5 mg oral tablet ○ 50 mg/ 2 mL Vial ○ 250 mg/ 10 mL Vial ○ 1 g Vial ○ 100 mg/ 4 mL Vial	○ Initial PO: Take 7.5 mg PO once weekly ○ Initial PO: Take 2.5 mg PO every 12 hrs x 3 doses per week ○ Initial IM: Inject 7.5 mg IM once weekly ○ Initial SC: Inject 7.5 mg SC once weekly ○ PO/ IM/ SC: Adjust dose gradually to optimal response (doses above 20 mg/week increase incidence of toxicity) _____ mg route: _____ once weekly		
Other: _____				

Prescriber Signature: _____ _____ Date: _____

Dispense as Written — Product Substitution Permitted