Rheumatology Enrollment Form A-K

Date: ____________________

Patient Name: ____________________

Date of Birth: ____________________

TwelveStone Health Partners

Fax Referral To: (615) 278-3355

Direct Phone: (844) 893-0012

Email: intake@12stonehealth.com

INFORMATION

Ship To:	Injection Training Provided by:
☐ Patient ☐ Physician/Clinic ☐ 1st Dose to Physician/Clinic, Remaining Refills to Patient	☐ Prescriber's Office ☐ Specialty Pharmacy ☐ Manufacturer ☐ Other: __________

CLINICAL INFORMATION- *(Please attach all clinical information, lab results, and other medical history documents)*

☐ Patient Demographics ☐ Medical Card (front and back) ☐ Prescription Card (front and back) ☐ Clinic Notes & Labs

Last 4 Digits of Social: ________ TB Test Completed: ☐ No ☐ Yes Date of negative test: ____/____/____ (Please send copy of results)

Patient Weight: ________ kg/lbs Height: ________ in/cm Allergies: ____________________

ICD-10: ____________________

Currently Receiving and/or Prior Failed Therapies:	☐ Biologics: __________ ☐ Corticosteroids ☐ Methotrexate ☐ NSAIDS ☐ Other: __________ Length of Treatment: __________ Reason for Discontinuing or Adding Supplemental Tx: __________	Contraindicated Medications: Reason:

MEDICATION	DOSE	DIRECTIONS	QUANTITY	REFILLS
☐ **ACTEMRA**	☐ 162mg Prefilled Syringe ☐ 162mg ACTPen Autoinjector	☐ (<100kg) Inject 162mg subcutaneously every other week ☐ (greater than or equal to 100kg) Inject 162mg subcutaneously every week		
☐ **BENLYSTA**	☐ 200mg Prefilled Syringe ☐ 200mg Autoinjector	☐ Inject 200mg subcutaneously every week		
☐ **CIMZIA**	☐ 200mg Prefilled Syringe	☐ Induction: Inject 400mg subcutaneously on Day 1, Week 2 and Week 4 ☐ Maintenance: Inject 200mg subcutaneously every other week ☐ Maintenance: Inject 400mg subcutaneously every 4 weeks		
☐ **COSENTYX**	☐ 150mg Prefilled Syringe ☐ 150mg Sensoready Pen	☐ Induction: Inject ________ mg subcutaneously at weeks 0, 1, 2, 3, and 4 ☐ Maintenance: Inject ________ mg subcutaneously every 4 weeks		
☐ **ENBREL**	☐ 50mg SureClick Autoinjector ☐ 50mg Mini Prefilled Cartridge	☐ Inject subcutaneously weekly		
☐ **EVENITY**	☐ 105mg Prefilled Syringe	☐ Inject 210mg SQ (two separate injections of 105mg each) every month for 12 doses		
☐ **FORTEO**	☐ 2.4ml Prefilled Pen (28 doses)	☐ Inject 20mcg SQ once daily		
☐ **HUMIRA Citrate Free**	☐ 40mg Prefilled Syringe ☐ 80mg Prefilled Syringe ☐ 40mg Pen ☐ 80mg Pen	☐ Inject ________ mg SQ every other week ☐ Inject ________ mg SQ every week		
☐ **KEVZARA**	☐ 150mg Prefilled Syringe ☐ 200mg Prefilled Syringe ☐ 150mg Pen ☐ 200mg Pen	☐ Inject ________ mg SQ every other week		
☐ **KINERET**	☐ 100mg Prefilled Syringe	☐ Inject 100mg SQ once daily ☐ Inject 100mg SQ every other day		

By signing below, I certify that the above therapy is medically necessary. Prescriber's Signature *(SIGN BELOW)*

By signing this form, I am authorizing TwelveStone Health Partners and affiliates to serve as my designated agent in submitting prior authorizations and other clinically required information to payors with respect to this patient and prescription order. This enrollment form shall serve as my signature for prior authorizations, as requested.

Dispense as Written: __________ Printed Name: __________ Substitution Allowed: __________ Date: __________

The information contained in this facsimile may be confidential and is intended solely for the use of the named recipient(s). Access, copying or re-use of the facsimile or any information contained therein by any other person is not authorized. If you are not the intended recipient, please notify us immediately by calling 615-895-0186 or faxing back to the originator.

Rheumatology Enrollment Form O-R

Date: ____________________

Patient Name: ____________________

Date of Birth: ____________________

TwelveStone Health Partners

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INFORMATION

Ship To:	Injection Training Provided by:
☐ Patient ☐ Physician/Clinic ☐ 1st Dose to Physician/Clinic, Remaining Refills to Patient	☐ Prescriber's Office ☐ Specialty Pharmacy ☐ Manufacturer ☐ Other: __________

CLINICAL INFORMATION- *(Please attach all clinical information, lab results, and other medical history documents)*

☐ Patient Demographics ☐ Medical Card (front and back) ☐ Prescription Card (front and back) ☐ Clinic Notes & Labs

Last 4 Digits of Social: __________ TB Test Completed: ☐ No ☐ Yes Date of negative test: ____/____/____ (Please send copy of results)

Patient Weight: __________ kg/lbs Height: __________ in/cm Allergies: ____________________

ICD-10: ____________________

Currently Receiving and/or Prior Failed Therapies:	☐ Biologics: __________ ☐ Corticosteroids ☐ Methotrexate ☐ NSAIDS ☐ Other: __________ Length of Treatment: __________ Reason for Discontinuing or Adding Supplemental Tx: __________	Contraindicated Medications: Reason:

MEDICATION	DOSE	DIRECTIONS	QUANTITY	REFILLS
☐ **OLUMIANT**	☐ 2mg Tablet	☐ Take one tablet by mouth once daily	30 Day Supply	
☐ **ORENCIA**	☐ 125mg Prefilled Syringe ☐ 125mg ClickJect Autoinjector	☐ Inject 125mg subcutaneously weekly (first dose one day after infusion)		
☐ **OTEZLA**	☐ Starter Pack	☐ Starter Pack: Take per package directions	28 Day Supply	
	☐ 30mg Tablet	☐ Take one tablet by mouth twice daily	30 Day Supply	
☐ **OTREXUP Autoinjector**	☐ 7.5mg ☐ 20mg ☐ 10mg ☐ 25mg ☐ 15mg	☐ Inject one pen subcutaneously every week		
☐ **PROLIA**	☐ 60mg Prefilled Syringe	☐ Inject 60mg subcutaneously every 6 months		
☐ **RASUVO Autoinjector**	☐ 7.5mg ☐ 20mg ☐ 10mg ☐ 22.5mg ☐ 12.5mg ☐ 25mg ☐ 15mg ☐ 27.5mg ☐ 17.5mg ☐ 30mg	☐ Inject one pen subcutaneously every week		
☐ **RINVOQ**	☐ 15mg Tablet	☐ Take one tablet by mouth once daily	30 Day Supply	

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Rheumatology Enrollment Form S-X

Date: ____________________

Patient Name: ____________________

Date of Birth: ____________________

TwelveStone Health Partners

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INFORMATION

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☐ Physician/Clinic	☐ Specialty Pharmacy
☐ 1st Dose to Physician/Clinic, Remaining Refills to Patient	☐ Manufacturer
	☐ Other: ______

CLINICAL INFORMATION- *(Please attach all clinical information, lab results, and other medical history documents)*

☐ Patient Demographics ☐ Medical Card (front and back) ☐ Prescription Card (front and back) ☐ Clinic Notes & Labs

Last 4 Digits of Social: ______ TB Test Completed: ☐ No ☐ Yes Date of negative test: ____/____/____ (Please send copy of results)

Patient Weight: ______ kg/lbs Height: ______ in/cm Allergies: ______

ICD-10: ______

Currently Receiving and/or Prior Failed Therapies:

☐ Biologics: ______ ☐ Corticosteroids

☐ Methotrexate ☐ NSAIDS

☐ Other: ______

Length of Treatment: ______

Reason for Discontinuing or Adding Supplemental Tx: ______

Contraindicated Medications:

Reason:

MEDICATION	DOSE	DIRECTIONS	QUANTITY	REFILLS
☐ **SIMPONI**	☐ 50mg Prefilled Syringe ☐ 50mg SmartJect Autoinjector	☐ Inject 50mg subcutaneously once a month		
☐ **SKYRIZI**	☐ 150mg Prefilled Pen ☐ 150mg Prefilled Syringe	☐ Inject 150mg subcutaneously at Week 0 and Week 4 ☐ Inject 150mg subcutaneously every 12 weeks		
☐ **STELARA**	☐ 45mg Prefilled Syringe ☐ 90mg Prefilled Syringe	☐ Inject ______ mg subcutaneously on Day 1, Week 4, then every 12 weeks ☐ Inject ______ mg subcutaneously every 12 weeks		
☐ **TALTZ**	☐ 80mg Prefilled Syringe ☐ 80mg Autoinjector	☐ Inject two 80mg injections subcutaneously at Week 0	2	0
		☐ Inject 80mg subcutaneously at Weeks 2, 4, 6, 8, 10 and 12	2	2
		☐ Inject 80mg subcutaneously every 4 weeks		
☐ **TREMFYA**	☐ 100mg Prefilled Syringe ☐ 100mg One-Press Injector	☐ Inject 100mg subcutaneously at Week 0 and Week 4 ☐ Inject 100mg subcutaneously every 8 weeks		
☐ **XELJANZ**	☐ 5mg Tablet	☐ Take one tablet by mouth twice daily	30 Day Supply	
☐ **XELJANZ XR**	☐ 11mg Tablet	☐ Take one tablet by mouth once daily	30 Day Supply	

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