MAXOR SPECIALTY
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Rheumatology Enrollment Form

Patient Information

Patient Name_____ ☐Male ☐Female
Date of Birth_____ ☐English ☐Spanish ☐Other_____
Address_____ Apt #_____
City_____ State_____ Zip_____
Phone # - Primary_____ Secondary_____
Email Address_____
Social Security #_____
Emergency Contact Name_____
Emergency Contact Phone_____

Please attach copy of insurance information or copy of insurance cards (both sides).

***Patient Authorization:** I authorize Maxor Specialty to enroll me in the applicable manufacturer's patient support program above to receive services such as, but not limited to, injection training. I further authorize Maxor Specialty to share minimum necessary information about my health condition and treatment to the manufacturer's program to provide educational materials on my related diagnosis, delivery of products and services offered by the program, and aggregated de-identified data for market analysis. I understand that I may revoke this authorization at any time by contacting Maxor Specialty. I also understand that I may refuse to sign this authorization and I will still be eligible for treatment by Maxor Specialty.

Patient Signature_____
Date_____

Physician Information

Physician Name_____
Physician NPI_____ License #_____
Office Contact Name_____
Address_____ Ste #_____
City_____ State_____ Zip_____
Phone_____ Fax_____

By signing this form, I authorize Maxor Specialty to act as my agent for Prior Authorizations & Prescription Reimbursement for the above listed patient.

Physician Signature_____ Date_____

☐ Dispense as written ☐ Product substitution permitted

****For Ohio patients, please only choose one (1) prescription per form.****

Shipping Information

☐New ☐Reauthorization ☐Restart
Date Medication Needed:_____
Ship to: ☐Patient's Home ☐Physician's Office
☐Other_____

Medical Information

(Please attach or complete all known medical history)

Allergies_____ ☐NKA
Weight_____ ☐kg ☐lb Height_____ ☐cm ☐in
BSA_____ m^2
Has patient had a positve TB test? ☐Yes ☐No
If yes, date of last chest x-ray:_____
Injection Training Needed ☐Yes ☐No

Diagnosis
Please include diagnosis name and ICD-9
Date of diagnosis:_____
☐714.0 Rheumatoid Arthritis
☐714.3 Juvenile Arthritis Idiopathic
☐720.0 Ankylosing Spondylitis
☐696.0 Psoriatic Arthritis
☐Other:_____

Failed Medications: (Please list.)
_____
_____
_____
_____
_____
_____
_____
_____
_____

Prescription Information

Medication	Dose/Strength	Directions	Qty	Refills
Actemra® ☐Enroll in Access Solutions*	☐4mg/kg ☐8mg/kg ☐162mg/0.9ml PFS	☐Infuse IV over 1 hour every 4 weeks ☐Other:_____ ☐<100kg inject 162mg SQ every other week, followed by an increase to every week based on clinical response ☐≥100kg inject 162mg SQ every week		
Cimzia® ☐Enroll in Cimplicity*	☐Cimzia Starter Kit ☐200mg/1ml PFS ☐200mg vial	**Initial Dose:** ☐Inject 400mg SQ at weeks 0, 2, & 4 **Maint Dose:** ☐Inject 200mg SQ every other week ☐Inject 400mg SQ every 4 weeks	1 kit (6 vials)	0
Enbrel® ☐Enroll in Enbrel Support*	☐50mg/ml Sureclick Autoinjector ☐50mg/ml PFS ☐25mg/0.5ml PFS ☐25mg vial	☐Inect 50mg SQ once a week ☐Inject 25mg SQ twice a week (72-96 hours apart) ☐Other:_____		
Humira® ☐Enroll in myHumira*	☐40mg/0.8ml Pen ☐40mg/0.8ml PFS	☐Inject 40mg SQ every other week ☐Other:_____		
Kineret® ☐KineretKare Program*	☐100mg PFS	☐Inject 100mg (one syringe) SQ once a day		
Orencia® ☐Enroll in On Call*	250mg Orencia vial ☐>100kg = 1000mg ☐60-100kg = 750mg ☐<60kg = 500mg	☐Infuse IV _____mg in 100ml of 0.9% NaCl at weeks 0, 2, & 4, then every 4 weeks thereafter ☐Infuse IV _____mg in 100ml of 0.9% NaCl as one-time loading dose, then begin SQ dosing within 24 hours ☐Other:_____		
	☐125mg Orencia SQ	☐Inject 125mg SQ every week		
Otezla®	☐Starter Pack ☐30mg Tablets	☐Titration: Take 1 tablet on day 1 then twice daily as directed ☐Take 1 tablet by mouth twice daily	1 Starter Pack 60	
Remicade® ☐Enroll in AccessOne*	☐3mg/kg ☐5mg/kg ☐_____mg/kg	**Initial Dose:** ☐IV in 250ml of 0.9% NaCl at weeks 0, 2, & 6 (ICD-9: 714.0, 696.0, & 720.0) **Maint Dose:** ☐IV in 250ml of 0.9% NaCl every 8 weeks (ICD-9: 714.0 & 696.0) ☐IV in 250ml of 0.9% NaCl every 6 weeks (ICD-9: 720.0) ☐Other:_____		
Rituxan® ☐Enroll in Access Solutions*	☐100mg/10ml vial ☐500mg/50ml vial	☐Infuse 1000mg in 1 liter of 0.9% NaCl on days 1 & 15 then every 24 weeks ☐Other:_____		
Stelara™	☐45mg ☐90mg	**Initial Dose:** ☐≤100kg (220lbs) 45mg SQ; repeat dose in 4 weeks ☐>100kg (220lbs) 90mg SQ; repeat dose in 4 weeks **Maint Dose:** ☐≤100kg (220lbs) 45mg Q 12 weeks starting at 16 weeks ☐>100kg (220lbs) 90mg Q 12 weeks starting at 16 weeks		
Simponi® ARIA™	☐2mg/kg	☐Infuse IV over 30 minutes, repeat dose in 4 weeks, then every 8 weeks thereafter ☐Other:_____		
Simponi® ☐Enroll in SimponiOne*	☐50mg/0.5ml PFS ☐50mg Smartject Autoinjector	☐Inject 50mg SQ every month		
Xeljanz® Eroll in Xelsource*	☐5mg Tablet	☐Take 5mg PO twice a day		

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