Gigi Specialty Pharmacy

Rheumatology/Biologics Enrollment Form

A Dose Of Kindness With Every Perscription.

Ship to: ☐ Patient ☐ Office ☐ Other: Date: Needs by Date:

PATIENT INFORMATION

*Please complete the following or **send patient demographic sheet***

Patient Name _____

Address _____

Address 2 _____

City, State, ZIP _____

Home Phone _____

Alternate Phone _____

DOB _____ Last Four of SS# _____ Gender _____

PRESCRIBER INFORMATION

Prescriber's Name _____

State License # _____ UPIN _____

DEA _____ NPI _____

Group/Hospital _____

Address _____

City, State, ZIP _____

Phone _____ Fax _____

Contact Person sdf Phone _____

INSURANCE INFORMATION

Prescription Card: Name of Insurer _____ ID # _____ BIN _____ PCN _____ Group _____

Primary Insurance: Subscriber _____ ID # _____ Name of Insurer _____ Phone _____

Secondary Insurance: Subscriber _____ ID # _____ Name of Insurer _____ Phone _____

MEDICAL INFORMATION

Diagnosis

Please include diagnosis name and ICD-10

☐ M 06.9 Rheumatoid Arthritis ☐ M 08.0 Juvenile Idiopathic Arthritis

☐ M 45.9 Ankylosing Spondylitis

☐ Other: ICD-10 _____ Diagnosis _____

Date of Diagnosis _____

Has a TB test been performed? ☐ Yes ☐ No

Does the patient have an active infection? ☐ Yes ☐ No

Start Date _____ **Review Date** _____

Additional Information Therapy: ☐ New ☐ Reauthorization ☐ Restart

Weight _____ kg/lbs Height _____ cm/in

Allergies _____

Lab Data _____

Prior Therapies _____

Concomitant Medications _____

Additional Comments _____

Injection Training Required: ☐ Yes ☐ No

PRESCRIPTION INFORMATION

Medication	Dose/Strength	Directions	Quantity	Refills
☐ Actemra (Genentech) ☐ Enroll in ACTIV*	☐ 80mg/4ml Vial ☐ 162mg/0.92ml Prefilled Syringe ☐ 200mg/10ml Vial ☐ 400mg/20ml Vial			
☐ Cimzia (UCB) ☐ Enroll in CIMplicity*	☐ 200mg/10ml Vial Kit ☐ 200mg/ml Starter Kit ☐ 200mg/10ml single use Prefilled Syringe			
☐ Enbrel (Amgen) ☐ Enroll in Enbrel Support*	☐ 50mg/ml SureClick Autoinjector ☐ 25mg/ml Vial ☐ 50mg/ml Prefilled Syringe ☐ 25mg/0.5ml Prefilled Syringe			
☐ Humira (Abbott) ☐ Enroll in myHUMIRA*	☐ 40mg/0.8ml Prefilled AutoPen ☐ 20mg/0.8ml Prefilled Syringe ☐ 40mg/0.8ml Prefilled Syringe			
☐ Orencia (BMS) ☐ Enroll in The Circle*	☐ 250mg Vial ☐ 125mg/ml single dose Prefilled Syringe			
☐ Remicade (Janssen) ☐ Enroll in AccessOne*	☐ 100mg/20ml Vial			
☐ Rituxan (Genentech) ☐ Enroll in RISE*	☐ 100mg/10ml Vial ☐ 500mg/50ml Vial			
☐ Simponi (Janssen) ☐ Enroll in SimponiOne*	☐ 50mg/0.5ml Smartject Autoinjector ☐ 50mg/0.5ml Prefilled Syringe			
☐ Xeljanz (Pfizer) ☐ Enroll in XELSOURCE*	☐ 5mg Tablet			
☐ *Stelara* 45mg Prefilled Syringe ☐ *Stelara* 90mg Prefilled Syringe	☐ Dispense 2 syringes ☐ Dispense 2 syringes	Sig: Inject contents of 1 syringe (45mg) subcutaneously on Day 0 and Day 28 Sig: Inject contents of 2 syringe (90mg) subcutaneously on Day 0 and Day 28		No Refills No Refills

***Patient Authorization:** I authorize NLSP to enroll me in the manufacturer's patient support program checked above to receive services such as, but not limited to, injection training. I further authorize NLSP to share minimum necessary information about my health condition and treatment to the manufacturer's program to provide educational materials on rheumatoid arthritis, 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 NLSP. I also understand that I may refuse to sign this authorization and I will still be eligible for treatment by NLSP

Patient's Signature _____ Date _____

Prescriber's Signature _____ _____

PRODUCT SUBSTITUTION PERMITTED *DISPENSE AS WRITTEN*

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