DolphinHealth Rx
Committed to Helping People Get Well

RHEUMATOLOGY ENROLLMENT AND RX FORM

Toll Free: 844-436-5744
Local Phone: 510-900-3131
Fax: 844-329-6979

1 PATIENT INFORMATION

Today's Date:
Need By Date:
Ship To:
☐ Patient
☐ Dr. office
☐ ____________

Patient Name:
Date of Birth:
SSN:
Address:
City, State, Zip Code:
Phone:
Email Address:
Preferred language:
Contact Person:

2 INSURANCE INFORMATION

PLEASE FAX A COPY (FRONT AND BACK) OF PATIENT'S CURRENT ACTIVE INSURANCE AND ID CARDS. FOR PATIENTS WITH BOTH MEDICARE AND MEDI-CAL, PLEASE FAX IN COPIES FOR BOTH.

3 SPECIAL INSTRUCTION

Training:
☐ Pharmacy will coordinate training for patient
☐ Provider will provide training
☐ Training not necessary

Delivery: ____________

4 CLINICAL INFORMATION

PLEASE FAX COPIES OF RECENT CHART NOTES, LABS, EVIDENCE OF DIAGNOSIS, AND CURRENT MEDICATION LIST.

5 DIAGNOSIS AND CLINICAL INFORMATION

Diagnosis (ICD-9 or ICD-10)

Date of Diagnosis ____________

☐ M06.9 Rheumatoid Arthritis ☐ M08.0 Juvenile Idiopathic Arthritis ☐ L40.59 Psoriatic Arthritis ☐ L40.54 Psoriatic Juvenile Arthritis

☐ M45.9 Ankylosing Spondylitis ☐ Other: ____________

Has patient had positive TB test? ☐ Yes ☐ No If yes, date of last chest x-ray: ____________

Height: ____________ Weight: ____________ Allergies: ____________

Previously Tried/Failed Medications- include dosage and frequency	Date of Trial	Reason for Discontinuation

6 PRESCRIPTION INFORMATION

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Actemra®	☐ 162 mg/0.9 mL Prefilled Syringe	☐ <100 kg: SQ every other week; increase to every week based on clinical response ☐ ≥100 kg: SQ 162 mg every week ☐ Other: ____________		
☐ Cimzia	☐ Cimzia Starter Kit	☐ Induction Dose: Inject 400mg subcutaneously on day 1, at week 2, and at week 4.	1 kit	
	☐ 200mg/1 mL Prefilled Syringe ☐ 200mg vial	☐ Maint. Dose: Inject 200mg subcutaneously ever OTHER week. ☐ Maint. Dose: Inject 400mg subcutaneously every 4 weeks. ☐ Other: ____________		
☐ Cosentyx®	☐ 150 mg/mL Sensoready Pen ☐ 150 mg/mL Prefilled Syringe ☐ 150 mg vial	☐ 300 mg sq at weeks 0,1,2,3, and 4, then 300 mg every 4 weeks ☐ 150 mg sq at weeks 0,1,2,3, and 4, then 150 mg every 4 weeks ☐ 150 mg sq every 4 weeks		
☐ Enbrel®*	☐ 50mg/ml Sureclick ☐ 50mg/ml Prefilled Syringe ☐ 25mg/0.5ml Prefilled Syringe ☐ 25mg Vial	☐ Inject 50mg subcutaneously ONCE a week. ☐ Inject 25mg subcutaneously TWICE a week (72-96 hours apart). ☐ Other: ____________		
☐ Humira®*	☐ 40mg/0.8ml Pen ☐ 40mg/0.8ml Prefilled Syringe ☐ 20mg/0.4ml Prefilled Syringe	☐ Inject 40mg subcutaneously every OTHER week. ☐ Inject 20mg subcutaneously every OTHER week. ☐ Inject 40 mg subcutaneously every week ☐ Other: ____________	☐ 1 carton (2 pens or PFS) ☐ 2 cartons (4 pens or PFS) Other ____________	
☐ Kineret ®	☐ 100mg Prefilled Syringe	☐ Inject 100mg (one syringe) SC once a day.		
☐ Orencia ®	☐ 125 mg Orencia Subcutaneous	☐ After single IV loading dose, inject 125mg subcutaneously within a day followed by 125mg subcutaneous injections every week thereafter ☐ For patients unable to receive an IV loading dose, inject 125mg subcutaneously every week ☐ For patients transitioning from IV infusion therapy to subcutaneous therapy, inject 125mg subcutaneously instead of the next scheduled IV dose followed by 125mg subcutaneous injections every week thereafter ☐ Inject 125mg subcutaneously every week		
☐ Otezla®	☐ 28-day Starter Pack ☐ Maintenance	☐ As directed on packaging ☐ Take 30 mg by mouth twice daily	☐ 55 tablets (one 28-day pack) ☐ 60 tablets ☐ Other ____________	
☐ Simponi®	☐ 50mg/0.5ml Prefilled SmartJect Autoinjector ☐ 50mg/0.5ml Prefilled Syringe	☐ Inject 50mg (0.5ml) subcutaneously once a month ☐ Other: ____________		
☐ Stelara®	☐ Injection 45 mg/0.5 mL in a single-use prefilled syringe ☐ Injection: 90 mg/mL in a single-use prefilled syringe	☐ The recommended dose is 45 mg SQ initially and 4 weeks later, followed by 45 mg SQ every 12 weeks. For patients with co-existent moderate-to-severe plaque psoriasis weighing >100 kg (220 lbs), the recommended dose is 90 mg initially and 4 weeks later, followed by 90 mg every 12 weeks		
☐ Xeljanz®	☐ 5mg	☐ Take one 5mg tablet PO twice daily ☐ Other: ____________	☐ 60 ☐ 120 ☐ 180	

7 PROVIDER AUTHORIZATION & INFORMATION

By signing below, the prescriber gives consent to both, the prescription(s) above, as well as to Dolphin Health to act as the prescriber's agent to begin and To execute the prior authorization process and to help the patient apply to co-pay assistance programs, including all foundations and manufacturer assistance programs if necessary.

Prescriber Name: ____________ Address: ____________

DEA: ____________ NPI: ____________ City, State, ZIP Code: ____________

Phone: ____________ Fax: ____________ Contact Person: ____________

Date: ____________ Provider Signature: ____________ ☐ Do not substitute