

RHEUMATOID ARTHRITIS ENROLLMENT FORM



DATE NEEDED: _____ MEDICATION/INJECTION START DATE: _____

Phone: 888.282.5166 Fax: 248.282.0471

Patient Information

Patient Name: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Date of Birth: _____
Daytime Phone: _____ Best Time to Call: _____
Cell Phone: _____ Best Time to Call: _____
E-Mail: _____
Patient's Primary Language: _____
Alternate Contact Name: _____
Alternate Contact Phone: _____
Ship to: Patient Physician Other: _____

Patient Insurance Information

Please copy front and back of medical and pharmacy insurance card and fax to Walgreens Specialty Pharmacy with this form. Medicare/Medicaid

Primary Insurer: _____
Telephone: _____
Policy ID #: _____ Group #: _____
Subscriber Name/Date of Birth: _____
Does this Plan Cover Prescription Drugs?: YES NO
Secondary Insurer: _____
Telephone: _____
Policy ID #: _____ Group #: _____
Subscriber Name/Date of Birth: _____
Does this Plan Cover Prescription Drugs?: YES NO
Employer: _____

PATIENT AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION

I authorize Walgreens Specialty Pharmacy to release any and all information it may have as necessary for Walgreens Specialty Pharmacy to (i) establish my eligibility for benefits; (ii) provide to me products, supplies or services; (iii) receive payment of benefits on my behalf; (iv) communicate with other healthcare providers regarding medical care provided, or to be provided, to me; (v) facilitate the provision of products, supplies, services or training required for my treatment through the product manufacturer, which may be used for promotional programs. I understand that my personal health information is subject to redisclosure. I have the right to revoke this authorization in writing at any time. I also have a right to receive a copy of this authorization. My refusal to sign this authorization will have no impact on receiving treatment from Walgreens Specialty Pharmacy. This authorization is valid for the duration of my treatment with Walgreens Specialty Pharmacy unless revoked in writing.

Patient Signature _____ Date _____

Patient Diagnosis Information

Please copy chart notes medication history and baseline lab results and fax to Walgreens Specialty Pharmacy with prescription

Diagnosis: _____ ICD-9 Code: _____ Date of diagnosis: _____ Height: _____ Weight: _____ Date of weight: _____
Choose one of the following: New Restart Currently on Therapy (Start Date: _____) Onset of Illness: _____
Previous Treatments: _____ Previous Therapy Start Date: _____ Previous Therapy Stop Date: _____
Previous Therapy Discontinuation Reason: _____
Allergies: _____
Other Medications Currently Taking: _____

Physician Information

Physician Name: _____ Site/Facility Name: _____
Street Address: _____ Specialty: _____
City: _____ St: _____ Zip: _____ Office Contact: _____ Telephone: _____
Fax: _____ Best Time to Call: _____ Office Contact E-Mail: _____
St. Lic. #: _____ DEA #: _____ NPI #: _____ UPIN #: _____
Office Hours: M - F _____ Sat: _____ Days Closed: _____

Prescription Information

<input type="checkbox"/> Enbrel [®] 25mg/0.5ml Pre-filled syringe (4 syringes)	<input type="checkbox"/> Enbrel [®] 25mg vials (4 week pak)	Qty: _____		
<input type="checkbox"/> Enbrel [®] 50mg/ml Pre-filled syringe (4 syringes)	<input type="checkbox"/> Enbrel [®] SureClick [™] Auto-Injector 50mg/ml (4 syringes)	Refill x _____		
Directions: _____				
<input type="checkbox"/> Humira [™] 40mg/syringe (2 syringes)	<input type="checkbox"/> Humira [™] 40mg/pen (2 syringes)	Qty: _____		
<input type="checkbox"/> Humira [™] 20mg/syringe (pediatric)		Refill x _____		
Directions: _____				
Kineret [®] (anakinra)	Strength: _____	Qty: _____	Directions: _____	Refill x _____
Remicade [®] (infliximab)	Strength: _____	Qty: _____	Directions: _____	Refill x _____
Orencia [®] (abatacept)	Strength: _____	Qty: _____	Directions: _____	Refill x _____
Rituxan [®] (rituximab)	Strength: _____	Qty: _____	Directions: _____	Refill x _____
Other: _____	Strength: _____	Qty: _____	Directions: _____	Refill x _____

Physician Signature: _____ Date: _____
Walgreens Specialty Pharmacy will confirm order upon receipt and follow up every 48 - 72 hours with insurance updates.
In order for a brand name product to be dispensed, the prescriber must hand write "BRAND NECESSARY" or "BRAND MEDICALLY NECESSARY" in the space below

Home Health Agency Nursing Visit Required Name of Agency: _____ Agency Phone Number: _____
Is Patient Enrolled in Manufacturer Support Program?: Yes No

FOR INTERNAL USE ONLY

Name: _____ Ext.: _____ Date: _____ Code: _____

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Fax to 4D for Prior Authorization:
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