BIOCURE

Rheumatology Enrollment Form

Phone: 713-360-2100 or 1-855-497-7956 | **Fax:**713-360-2105 or 1-855-497-7957

Ship To: ☐ Patient ☐ Physician ☐ Other **Ship By:** _____

A to O Medication

Patient Information

Name: _____

DOB: _____ Gender: ☐ M ☐ F SSN: _____

Language: ☐ Eng ☐ Span ☐ Other:_____ Weight: _____ ☐ Lbs ☐ Kgs

Address: _____

City: _____ State: _____ Zip: _____

Home #: _____ Work #: _____

Cell #: _____

Allergies: _____ ☐ NKDA

Prescriber Information

Prescriber: _____

DEA: _____ NPI: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____

Cell #: _____ Fax #: _____

Office Contact: _____

☐ Initiate Appeal Reason: _____

**** INSURANCE INFORMATION: PLEASE FAX COPY OF PRESCRIPTION CARD, FRONT AND BACK AS WELL AS ALL CLINIC NOTES ****

Clinical Information

DIAGNOSIS (Description & ICD 10 Code): _____ **Current Medications:** _____

☐ Nurse Training ☐ In Patient Home or Clinic ☐ In Physician's Office

TB/PPD test given or intended to be given before start ☐ Yes ☐ No Results _____

Prior Failed Medications	Length of Treatment	Reason for Discontinuing

Medication	Strength	Directions	QTY	Refill
☐ Actemra	☐ 162mg Prefilled Syringe ☐ Vials	☐ Inject 1 syringe subcontaneously every OTHER week (< 100k) ☐ Inject 1 syringe subcontaneously ONCE per week (≥ 100k) ☐ Infuse _____ mg/kg = _____ mg IV every 4 weeks	4 week supply	
☐ Benlysta	Initial: ☐ 120mg Vial ☐ 400mg Vial	☐ Infuse 10mg / kg = _____ mg IV at weeks 0, 2 and 4	4 week supply	0
	Maintenance: ☐ 120mg Vial ☐ 400mg Vial	☐ Infuse 10mg / kg = _____ mg IV every 4 weeks		
☐ Cimzia	Starter: ☐ 200mg Prefilled Syringe Starter Kit (6 doses) ☐ 200mg Vial X 3 Cartons (6 doses)	☐ Inject TWO 200mg injections (400mg) subcutaneously at weeks 0, 2 and 4	4 week supply	0
	Maintenance: ☐ 200mg Prefilled Syringe (2 doses / kit) ☐ 200mg Vials (2 doses / kit)	☐ Inject TWO 200mg injections (400mg) subcutaneously every 4 weeks ☐ Inject 200mg subcutaneously every 2 weeks	4 week supply	
☐ Cosentyx	Starter: ☐ 150 mg Pen ☐ 150 mg PFS	☐ Inject 150 mg subcutaneously once weekly for 5 weeks	5 week supply	0
	Maintenance: ☐ 150 mg Pen ☐ 150 mg PFS	☐ Inject 150 mg subcutaneously every 4 weeks there after	4 week supply	
☐ Enbrel	☐ 50mg SureClick (4 doses / kit) ☐ 50mg Prefilled Syringe (4 doses / kit) ☐ 50mg Mini Cartridge (4 doses / kit) ☐ 25mg Prefilled Syringe (4 doses / kit) ☐ 25mg Vials (4 doses / kit)	☐ Inject 50mg subcontaneously ONCE a week ☐ Inject 50mg subcontaneously TWICE a week 72 - 96 hrs apart ☐ Inject 25mg subcontaneously TWICE a week 72 - 96 hrs apart	4 week supply	
☐ Forteo	☐ 2.4ml Pen (28 doses) with Pen Needles	☐ Inject 20mcg subcontaneously ONCE a day	4 week supply	
☐ Humira	☐ 40mg Pen (2 doses / kit) ☐ 40mg Prefilled Syringe (2 doses / kit)	☐ Inject 40mg subcontaneously every other week ☐ Inject 40mg subcontaneously ONCE per week	4 week supply	
☐ Orencia	Initial: ☐ 250mg Vial	☐ Infuse with 100ml 0.9% NaCl weight based dose X 1 or ☐ week 0 and 2 ☐ Less than 60kg 500mg (2 vials) ☐ 60 to 100kg 750mg (3vials) ☐ More than 100kg 1000mg (4 vials)	Pharmacist to QS	0
	Maintenance: ☐ 125mg Prefilled Syringe ☐ 250mg Vial	☐ Inject 125mg subcontaneously within a day of initial infusion ☐ Inject 125mg subcontaneously ONCE weekly ☐ Infuse in 100ml 0.9% NaCl 4 weeks after initial and every 4 weeks thereafter ☐ Less than 60kg 500mg (2 vials) ☐ 60 to 100kg 750mg (3vials) ☐ More than 100kg 1000mg (4 vials)	4 week supply	
☐ Otezla	Please use Otezla form and specify BioCure as preferred specialty pharmacy. Forward all clinical notes. (www.biocurerx.com/referral-forms/)			

Additional Inforamtion

Prescriber Signature: _____ **Date:** _____

I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment. By signing this form and utilizing our services, you are authorizing BioCure LLC and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies and Co-pay Assistance Foundations

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☐ Nurse Training ☐ In Patient Home or Clinic ☐ In Physician's Office

TB/PPD test given or intended to be given before start ☐ Yes ☐ No Results: _____

Prior Failed Medications	Length of Treatment	Reason for Discontinuing

Medication	Strength	Directions	QTY	Refill
☐ Remicade ☐ Inflectra	Initial: ☐ 100mg Vial	☐ Infuse _____ mg/kg = _____ mg at 0, 2, and 6 weeks	Pharmacist to QS	0
	Maintenance: ☐ 100mg Vial	☐ Infuse _____ mg/kg = _____ mg every _____ weeks	Pharmacist to QS	
☐ Rituxan	☐ 500mg / 50ml Vial	☐ Infuse 1000mg IV day 0 and day 14	4	
☐ Stelara	Starter: ☐ 45mg Prefilled Syringe (1 dose) ≤ 100kg ☐ 90mg Prefilled Syringe (1 dose) > 100kg	☐ Inject 45mg subcontaneously on Day 1 (≤ 100kg) ☐ Inject 90mg subcontaneously on Day 1 (> 100kg)	1	0
	Maintenance: ☐ 45mg Prefilled Syringe (1 dose) ≤ 100kg ☐ 90mg Prefilled Syringe (1 dose) > 100kg	☐ Inject 45mg subcontaneous on Day 29 and every 12 weeks thereafter (≤ 100kg) ☐ Inject 90mg subcontaneous on Day 29 and every 12 weeks thereafter (> 100kg)	1	
☐ Simponi	☐ 50mg SmartJect ☐ 50mg Prefilled Syringe	☐ Inject 50mg subcontaneously ONCE a month	1	
☐ Simpon Aria	Initial: ☐ 50mg / 4ml Vial (12.5mg / ml)	☐ Infuse 2 mg/kg = _____ mg over 30 minutes at week 0	Pharmacist to QS	0
	Maintenance: ☐ 50mg / 4ml Vial (12.5mg / ml)	☐ Infuse 2 mg/kg = _____ mg over 30 minutes at week 4 and every 8 weeks thereafter	Pharmacist to QS	
☐ Xeljanz	☐ 5mg Tab	☐ Take 5mg PO twice daily ☐ Take 5mg PO daily (renal and hepatic impairment)	4 week supply	
☐ Xeljanz XR	☐ 11mg XR Tab	☐ Take 11mg PO daily	30	

Additional Information

Prescriber Signature: _____ **Date:** _____

I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment. By signing this form and utilizing our services, you are authorizing BioCure LLC and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies and Co-pay Assistance Foundations