Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy

AccuSERV® PHARMACY

Rheumatology Enrollment Form (A-K)

Clear Form

Fax: (877) 526-8823

Pharmacy Phone: (866) 213-9821 Single Point of Contact: (724) 515-7053

1. Patient Information

Start Date:_____ Ship to: ☐ Patient ☐ Office _____Other

Patient Name: _____ ○Male ○Female DOB:_____

Address: _____

Soc. Sec. # _____ Phone #:_____ Alt Phone #:_____

Caregiver:_____ Allergies: _____

Comorbidities: _____ Height:_____ Weight: _____

2. Clinical Information

please fax recent clinical notes, labs & tests with prescription to expedite the prior authorization

ICD -10/ Diagnosis Code:_____ TB Test: ○yes ○no Date of Negative Result:_____

Prior Therapies: _____

Reason for Discontinuation: _____

3. Prescription Information

if your selection (Medication/ Directions/ QTY) is not shown below please write it in the space provided

✘	Medication	Dose / Strength	Directions (be specific)	Quantity	Refills
☐	Cimzia®	Starter Dose ○ 200mg /mL PFS	○ inject 400mg Sub-Q at weeks 0,2 & 4 ○	○ Starter kit (6 PFS) ○	
		Maintenance Dose ○ 200mg / mL PFS	○ inject 400mg Sub-Q every 4 weeks ○ inject 200mg Sub-Q every 2 weeks	○ 2 PFS ○	
☐	Duzallo®	○ 200/300 mg	○ Take 1 tablet daily	○ 30 tablets	
☐	Enbrel®	○ 25mg/0.5mL PFS ○ 25mg Vial ○ 50mg/mL *SureClick*® ○ 50mg/mL PFS ○ 50mg/mL 0.98mL (Mini)	○ inject 50mg Sub-Q once a week ○ inject 25mg Sub-Q once a week ○	○ 4 *SureClick*® ○ 4 PFS ○ 4 vials ○ 4 *Enbrel Mini*®	
☐	Forteo®	○ 600 mcg/ 2.4mL PFS	○ inject 20mcg Sub-Q once a day ○	○ 1 PFS	
☐	Humira®	○ 40mg/ 0.8mL Pen ○ 40mg/ 0.8mL PFS ○	○ inject 40mg Sub-Q every other week ○ inject 40mg Sub-Q once a week ◉	○ 2 Pens ○ 4 Pens ○ 2 PFS ○	
☐	Kevzara®	○ 150mg/1.14mL PFS ○ 200mg/1.14mL PFS	○ inject 150mg Sub-Q every other week ○ inject 200mg Sub-Q every other week ○	○ 2 PFS ○	
☐	Kineret®	○ 100mg/ 0.67mL PFS	◉ inject 100mg Sub-Q once a day at approximately the same time each day ○	○ 28 PFS _____ PFS	
☐					

4. Prescriber and Shipping Information

Prescriber (print) : _____ Office Contact: _____

Pref. Method of Contact: ○ phone ○ fax ○ email Contact email: _____

Office Address: _____

Phone: _____ Fax: _____

NPI: _____ DEA: _____

Prescriber's Signature: _____ Date: _____

I authorize AccuServ Pharmacy and its representative to act as an agent to initiate and execute the insurance prior authorization process. (NO STAMPS)

5. Insurance Information

Please fax a copy of insurance card front and back. Enlarge if possible.

Please fax completed form to AccuServ Pharmacy at (877) 526-8823. Visit us at WWW.ACCUSERVPHARMACY.COM for online fillable forms.