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

AccuSERV® PHARMACY

Rheumatology Enrollment Form (L-Z)

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
☐	Orencia®	○ 125mg/mL PFS ○ 125mg/mL *ClickJet*® ○	○ Inject 125mg Sub-Q once a week ○	○ 4 PFS ○ 4 *ClickJet*® ○	
☐	Otezla®	Starter Dose: ○ 4 wk start pack (10/20/30mg)	○ Take as directed on (28 day Starter Pack) packaging	○ 1 Starter pack (55 tablets)	
		Maintenance Dose: ○ 30mg tablet	○ Take 1 tablet by mouth twice a day ○	○ 60 Tablets ○	
☐	Prolia®	○ 60mg/1mL PFS	○ Inject 60mg Sub-Q once every 6 months	○ 1 PFS	
☐	Remicade®	○ 100mg/20mL Vial	○ Use as directed per package instructions ○	○ 1 Vial ○	
☐	Simponi®	○ 50mg/ 0.5mL PFS ○ 50mg/0.5mL *SmartJect*®	○ Inject 50mg Sub-Q once monthly ○	○ 1 *SmartJect*® ○ 1 PFS ○	
☐	Stelara®	Starter Dose ○ 45mg/ 0.5mL PFS ○ 90mg /mL PFS	○ Inject 1 PFS Sub-Q on Day 1 ○	○ 1 PFS	
		Maintenance Dose ○ 45mg/ 0.5mL PFS ○ 90mg /mL PFS	○ Inject 1 PFS Sub-Q on day 29 & every 12wks after ○ Inject 1 PFS every 12 weeks	○ 1 PFS ○	
☐	Xeljanz®	○ 5mg tablet	○ Take 1 tablet by mouth twice a day	○ 60 tablets	
☐	Xeljanz XR®	○ 11mg tablet	○ Take 1 tablet by mouth daily	○ 30 tablets	
☐	Vimovo®	○ 375-20mg ○ 500-20mg	○ Take 1 tablet twice a day, 30 min before meal	○ 60 tablets	
☐					

4. Prescriber and Shipping Information

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

Prescriber (print): _____ Office Contact: _____

Contact email: _____Phone:_____Fax:_____

Office Address: _____

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.