Rheumatology Enrollment Form A-K

Date: ____________________

Patient Name: ____________________

Date of Birth: ____________________

TwelveStone Health Partners

Fax Referral To: (800) 223-4063

Direct Phone: (615) 278-3350

Toll Free: (844) 893-0012

INFORMATION

Ship To:	Injection Training Provided by:
☐ Patient	☐ Prescriber's Office
☐ Physician/Clinic	☐ Specialty Pharmacy
☐ 1st Dose to Physician/Clinic, Remaining Refills to Patient	☐ Manufacturer
	☐ Other: ________

CLINICAL INFORMATION- *(Please attach all clinical information, lab results, and other medical history documents)*

☐ Patient Demographics ☐ Medical Card (front and back) ☐ Prescription Card (front and back) ☐ Clinic Notes & Labs

Last 4 Digits of Social: ________ TB Test Completed: ☐ No ☐ Yes Date of negative test: ____/____/____ (Please send copy of results)

Patient Weight: ________ kg/lbs Height: ________ in/cm Allergies: ____________________

ICD-10: ____________________

Currently Receiving and/or Prior Failed Therapies:

☐ Biologics: ____________ ☐ Corticosteroids

☐ Methotrexate ☐ NSAIDS

☐ Other: ____________________

Length of Treatment: ____________________

Reason for Discontinuing or Adding Supplemental Tx: ____________________

Contraindicated Medications:

Reason:

MEDICATION	DOSE	DIRECTIONS	QUANTITY	REFILLS
☐ ACTEMRA	☐ 162mg Prefilled Syringe ☐ 162mg ACTPen Autoinjector	☐ (<100kg) Inject 162mg subcutaneously every other week ☐ (greater than or equal to 100kg) Inject 162mg subcutaneously every week		
☐ BENLYSTA	☐ 200mg Prefilled Syringe ☐ 200mg Autoinjector	☐ Inject 200mg subcutaneously every week		
☐ CIMZIA	☐ 200mg Prefilled Syringe	☐ Induction: Inject 400mg subcutaneously on Day 1, Week 2 and Week 4 ☐ Maintenance: Inject 200mg subcutaneously every other week ☐ Maintenance: Inject 400mg subcutaneously every 4 weeks		
☐ COSENTYX	☐ 150mg Prefilled Syringe ☐ 150mg Sensoready Pen	☐ Induction: Inject ________ mg subcutaneously at weeks 0, 1, 2, 3, and 4 ☐ Maintenance: Inject ________ mg subcutaneously every 4 weeks		
☐ ENBREL	☐ 50mg SureClick Autoinjector ☐ 50mg Mini Prefilled Cartridge	☐ Inject subcutaneously weekly		
☐ EVENITY	☐ 105mg Prefilled Syringe	☐ Inject 210mg SQ (two separate injections of 105mg each) every month for 12 doses		
☐ FORTEO	☐ 2.4ml Prefilled Pen (28 doses)	☐ Inject 20mcg SQ once daily		
☐ HUMIRA Citrate Free	☐ 40mg Prefilled Syringe ☐ 80mg Prefilled Syringe ☐ 40mg Pen ☐ 80mg Pen	☐ Inject ________ mg SQ every other week ☐ Inject ________ mg SQ every week		
☐ KEVZARA	☐ 150mg Prefilled Syringe ☐ 200mg Prefilled Syringe ☐ 150mg Pen ☐ 200mg Pen	☐ Inject ________ mg SQ every other week		
☐ KINERET	☐ 100mg Prefilled Syringe	☐ Inject 100mg SQ once daily ☐ Inject 100mg SQ every other day		

By signing below, I certify that the above therapy is medically necessary. Prescriber's Signature *(SIGN BELOW)*

By signing this form and utilizing our services, I am also authorizing TwelveStone to serve as my prior authorization agent with medical and pharmacy insurance providers.

Dispense as Written: ____________ Printed Name: ____________ Substitution Allowed: ____________ Date: ________

V 9.15.23

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Rheumatology Enrollment Form O-R

Date: ____________________

Patient Name: ____________________

Date of Birth: ____________________

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Patient Weight: __________ kg/lbs Height: __________ in/cm Allergies: ____________________

ICD-10: ____________________

Currently Receiving and/or Prior Failed Therapies:

☐ Biologics: ____________ ☐ Corticosteroids

☐ Methotrexate ☐ NSAIDS

☐ Other: ____________________

Length of Treatment: ____________________

Reason for Discontinuing or Adding Supplemental Tx: ____________________

Contraindicated Medications:

Reason:

MEDICATION	DOSE	DIRECTIONS	QUANTITY	REFILLS
☐ OLUMIANT	☐ 2mg Tablet	☐ Take one tablet by mouth once daily	30 Day Supply	
☐ ORENCIA	☐ 125mg Prefilled Syringe ☐ 125mg ClickJect Autoinjector	☐ Inject 125mg subcutaneously weekly (first dose one day after infusion)		
☐ OTEZLA	☐ Starter Pack	☐ Starter Pack: Take per package directions	28 Day Supply	
	☐ 30mg Tablet	☐ Take one tablet by mouth twice daily	30 Day Supply	
☐ OTREXUP Autoinjector	☐ 7.5mg ☐ 10mg ☐ 15mg ☐ 20mg ☐ 25mg	☐ Inject one pen subcutaneously every week		
☐ PROLIA	☐ 60mg Prefilled Syringe	☐ Inject 60mg subcutaneously every 6 months		
☐ RASUVO Autoinjector	☐ 7.5mg ☐ 10mg ☐ 12.5mg ☐ 15mg ☐ 17.5mg ☐ 20mg ☐ 22.5mg ☐ 25mg ☐ 27.5mg ☐ 30mg	☐ Inject one pen subcutaneously every week		
☐ RINVOQ	☐ 15mg Tablet	☐ Take one tablet by mouth once daily	30 Day Supply	

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Rheumatology Enrollment Form S-X

Date: ______

Patient Name: ______

Date of Birth: ______

TwelveStone Health Partners

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Direct Phone: (615) 278-3350

Toll Free: (844) 893-0012

INFORMATION

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☐ Other: ______

Length of Treatment: ______

Reason for Discontinuing or Adding Supplemental Tx: ______

Contraindicated Medications:

Reason:

MEDICATION	DOSE	DIRECTIONS	QUANTITY	REFILLS
☐ SIMPONI	☐ 50mg Prefilled Syringe ☐ 50mg SmartJect Autoinjector	☐ Inject 50mg subcutaneously once a month		
☐ SKYRIZI	☐ 150mg Prefilled Pen ☐ 150mg Prefilled Syringe	☐ Inject 150mg subcutaneously at Week 0 and Week 4 ☐ Inject 150mg subcutaneously every 12 weeks		
☐ STELARA	☐ 45mg Prefilled Syringe ☐ 90mg Prefilled Syringe	☐ Inject ______ mg subcutaneously on Day 1, Week 4, then every 12 weeks ☐ Inject ______ mg subcutaneously every 12 weeks		
☐ TALTZ	☐ 80mg Prefilled Syringe ☐ 80mg Autoinjector	☐ Inject two 80mg injections subcutaneously at Week 0	2	0
		☐ Inject 80mg subcutaneously at Weeks 2, 4, 6, 8, 10 and 12	2	2
		☐ Inject 80mg subcutaneously every 4 weeks		
☐ TREMFYA	☐ 100mg Prefilled Syringe ☐ 100mg One-Press Injector	☐ Inject 100mg subcutaneously at Week 0 and Week 4 ☐ Inject 100mg subcutaneously every 8 weeks		
☐ XELJANZ	☐ 5mg Tablet	☐ Take one tablet by mouth twice daily	30 Day Supply	
☐ XELJANZ XR	☐ 11mg Tablet	☐ Take one tablet by mouth once daily	30 Day Supply	

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