LINDEN
RETAIL SPECIALTY PHARMACY

RHUEMATOLOGY ENROLLMENT FORM

Phone: 908-583-6665 | Fax: 888-474-0976
Email: lindensprx@gmail.com

SIX SIMPLE STEPS TO SUBMITTING A REFERRAL

1 PATIENT INFORMATION (Complete or include demographic sheet)

Patient Name _____ Address _____ City, State, ZIP _____

Preferred Contact Methods ☐ Phone (to primary # provided below) ☐ Text (to cell # provided below) ☐ Email (to email provided below)

Note: Carrier charges may apply. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.

Primary Phone _____ Alternate Phone _____ Date of Birth _____ Gender ◯ Male ◯ Female

Email _____ Last Four of SSN _____ Primary Language _____

2 PRESCRIBER INFORMATION

Prescriber's Name _____ State License Number _____

NPI Number _____ DEA Number _____ Group or Hospital _____

Address _____ City, State, ZIP _____

Phone _____ Fax _____ Contact Person _____ Contact's Phone _____

3 INSURANCE INFORMATION Please fax copy of prescription and insurance cards with this form, if available (front and back)

4 DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date _____ Ship to ☐ Patient ☐ Office ☐ Other _____

Diagnosis (ICD-10):

☐ M06.9 Rheumatoid Arthritis, Unspecified
☐ L40.50 Arthropathic Psoriasis, Unspecified
☐ M08.00 Unspecified Juvenile Rheumatoid Arthritis of Unspecified Site
☐ M45.9 Ankylosing Spondylitis of Unspecified Sites in Spine
☐ L40.59 Other Psoriatic Arthropathy
☐ Other Code: _____ Description _____

For additional ICD-10 information, please visit Linden Retail Specialty Pharmacy Professionals Website

Patient Clinical Information

Allergies _____ Weight _____ lb/kg Height _____ in/cm TB Test Result _____ Date _____

Nursing

Specialty pharmacy to coordinate injection training/ home health infusion nurse visit necessary ◯ Yes ◯ No

Site of Care ☐ MD Office ☐ infusion clinic ☐ Outpatient Health ☐ Home Health

Injection training not necessary. Date training occurred: _____

Reason ☐ MD office training patient ☐ Pt already independent ☐ Referred by MD to alternate trainer

5 PRESCRIPTION INFORMATION

MEDICATIONS	STRENGHT	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Actemra	☐ 80 mg/4 mL ☐ 200 mg/10 mL ☐ 400 mg/20 mL	☐ Induction Dose: Infuse 4 mg/kg every 4 weeks. ☐ Maintenance Dose: Infuse 8 mg/kg every 4 weeks. ☐ Other: _____	Quantity: _____ Refills: _____
☐ Actemra	162mg/0.9 mL prefilled syringe	☐ For patients weighing <100kg: Inject 162mg SC every other week, followed by an increase to every week based on clinical response ☐ For patients weighing ≥ 100kg: Inject 162mg SC every week.	Quantity: _____ Refills: _____
☐ Cimzia	Cimzia Starter Kit (6 prefilled syringes)	Induction Dose: 400 mg initially and at week 2 and 4, (given as 2 SC of 200 mg each) followed by 200 mg every other week;	Quantity: 1 Kit Refills: 0
☐ Cimzia	☐ 200mg/1 mL prefilled syringe ☐ 200mg vial	☐ Maintenance Dose: Inject 200mg SC every OTHER week. ☐ Maintenance Dose: Inject 400mg SC every four weeks. ☐ Other _____	Quantity: _____ Refills: _____

Patient is interested in patient support programs

STAMP SIGNATURE NOT ALLOWED

Ancillary supplies and kits provided as needed for administration

6 PYSICIAN SIGNATURE REQUIRED

PRODUCT SUBSTITUTION PERMITTED _____ DATE _____ DISPENSE AS WRITTEN _____ DATE _____

Medication C - K
Rheumatology Enrollment Form
(Cosentyx®, Enbrel®, Humira®, Ilaris®)

Please complete Patient and Prescriber Information

Patient Name _____ Patient Date of Birth _____

Prescriber Name _____ Prescriber Phone _____

5 PRESCRIPTION INFORMATION

MEDICATIONS	STRENGHT	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Cosentyx	☐ Sensoready® pen150 mg/mL injection ☐ Prefilled syringe 150 mg/mL injection	Psoriatic Arthritis with Coexistent Moderate to Severe Plaque Psoriasis ☐ Loading Dose: Inject 300 mg (two injections) SC at weeks 0, 1, 2, 3 and 4. ☐ Maintenance Dose: Inject 300 mg (two injections) SC every 4 weeks. Other Psoriatic Arthritis or Ankylosing Spondylitis ☐ With Loading Dose: Inject 150 mg (one injection) SC at weeks 0, 1, 2, 3 and 4, and then every 4 weeks thereafter. ☐ Without Loading Dose: Inject 150 mg (one injection) SC every 4 weeks ☐ Other _____	Quantity: _____ Refills: _____
☐ Enbrel	☐ 25mg/0.5 mL prefilled syringe ☐ 25mg vial Autoinjector ☐ 50mg/mL prefilled syringe ☐ 50 mg/mL Enbrel Mini™ prefilled cartridge for use with the AutoTouch™ reusable autoinjector only (Prescriber MUST supply). Linden does not order the autoinjector.	☐ Inject 25mg SC TWICE a week (72 – 96 hours apart). ☐ Inject 50mg SC ONCE a week. ☐ Other: _____	Quantity: _____ Refills: _____
☐ Humira	☐ 40 mg/0.4 mL Pen **(Citrate Free)** ☐ 40 mg/0.4 mL Prefilled Syringe **(Citrate Free)** ☐ 40 mg/0.8 mL Pen ☐ 40 mg/0.8 mL Prefilled Syringe	☐ Inject 40mg SC every OTHER week. ☐ Other: _____	Quantity: _____ Refills: _____
☐ Ilaris	150 mg/mL injection solution	For patients weighing ≥ 7.5 kg: Inject 4 mg/kg (with a maximum of 300 mg) SC every 4 weeks. Each single-dose vial of ILARIS (canakinumab) Injection delivers 150 mg/mL sterile, preservative-free, clear to slightly opalescent, colorless to a slight brownish to yellow solution.	Quantity: _____ Refills: _____

Patient is interested in patient support programs **STAMP SIGNATURE NOT ALLOWED** Ancillary supplies and kits provided as needed for administration

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PRODUCT SUBSTITUTION PERMITTED _____ DATE _____ DISPENSE AS WRITTEN _____ DATE _____

Medication I - Q
Rheumatology Enrollment Form
(Inflectra® Kevzara®, Olumiant®, Orencia®, Otezla®)

Please complete Patient and Prescriber Information

Patient Name _____ Patient Date of Birth _____

Prescriber Name _____ Prescriber Phone _____

5 PRESCRIPTION INFORMATION

MEDICATIONS	STRENGHT	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Inflectra	100 mg vial	☐ Rheumatoid Arthritis Induction Dose: In conjunction with methotrexate Infuse IV at 3 mg/kg (Dose = _____ mg) at weeks 0, week 2, week 6 and every 8 weeks thereafter. ☐ Rheumatoid Arthritis Maintenance Dose: Infuse 3 mg/kg every 8 weeks. ☐ Psoriatic Arthritis Induction Dose: Infuse IV at 5 mg/kg (Dose = _____ mg) at weeks 0, week 2, week 6 and every 8 weeks thereafter. ☐ Psoriatic Arthritis Maintenance Dose: Infuse 5 mg/kg every 8 weeks. ☐ Other: _____	Quantity: _____ Number of 100 mg vial Refills: _____
☐ Kevzara	☐ 200 mg/1.14 mL prefilled syringe (pk of 2) ☐ 150 mg/1.14 mL prefilled syringe (pk of 2) ☐ 200 mg/1.14 mL prefilled pen (pk of 2) ☐ 150 mg/1.14 mL prefilled pen (pk of 2)	☐ Inject 200 mg SC once every two weeks. ☐ Inject 150 mg SC once every two weeks.	Quantity: _____ Refills: _____
☐ Olumiant	2 mg tablet	Take 2 mg PO once daily	Quantity: _____ Refills: _____
☐ Orencia	☐ 25mg prefilled syringe ☐ ClickJect Autoinjector 125 mg/mL pack of 4	☐ Inject 125mg SC every week ☐ After Single IV Loading Dose: Inject 125mg SC within a day and 125mg SC every week thereafter. ☐ Patients Unable to Receive an IV Loading Dose: Inject 125 mg SC every week. ☐ Patients Transitioning from IV Infusion Therapy: Inject 125 mg SC instead of the next scheduled IV dose, followed by 125mg SC injections every week thereafter.	Quantity: _____ Refills: _____
☐ Orencia	250 mg vial	☐ Infuse _____ mg at weeks 0, 2 and 4, then every 4 weeks thereafter. ☐ Other: _____	Quantity: _____ Refills: _____
☐ Otezla	Titration Starter Pack	Day 1: 10 mg PO in the morning. Day 2: 10 mg PO in the morning and 10 mg PO in the evening Day 3: 10 mg PO in the morning and 20 mg PO in the evening Day 4: 20 mg PO in the morning and 20 mg PO in the evening Day 5: 20 mg PO in the morning and 30 mg PO in the evening Day 6 and thereafter: 30 mg PO twice daily.	Quantity: _____ Refills: _____
☐ Otezla	30 mg tablet	☐ Maintenance Dose: 30 mg PO twice daily. ☐ Other: _____	Quantity: _____ Refills: _____

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PRODUCT SUBSTITUTION PERMITTED _____ DATE _____ DISPENSE AS WRITTEN _____ DATE _____

Medication R - Z
Rheumatology Enrollment Form

(Remicade®, Renflexis®, Rituxan®, Simponi®, Simponi ARIA®, Stelara®, Taltz®, Xeljanz®, Xeljanz XR®)

Please complete Patient and Prescriber Information

Patient Name _____ Patient Date of Birth _____

Prescriber Name _____ Prescriber Phone _____

5 PRESCRIPTION INFORMATION

MEDICATIONS	STRENGHT	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Remicade	100 mg vial	☐ Induction Dose: Infuse _____ mg/kg at weeks 0, 2 and 6. ☐ Maintenance Dose: Infuse _____ mg/kg every 6 weeks. ☐ Maintenance Dose: Infuse _____ mg/kg every 8 weeks. ☐ Other: _____	Quantity: _____ Refills: _____
☐ Renflexis	100 mg vial	☐ Induction Dose: Infuse IV at 5 mg/kg (Dose = _____ mg) at week 0, week 2, week 6 and every 8 weeks thereafter. ☐ Maintenance Dose: Infuse 5 mg/kg every 8 weeks. ☐ Other: _____	Quantity: _____ Number of 100 mg vial Refills: _____
☐ Rituxan	☐ 100 mg/10 mL vial ☐ 500 mg/50 mL vial	☐ Infuse two doses of 1000 mg separated by 2 weeks. ☐ Other: _____	Quantity: _____ Refills: _____
☐ Simponi	☐ 50mg/0.5mL prefilled SmartJect® Autoinjector ☐ 50mg/0.5mL prefilled syringe	☐ Inject 50mg SC once a month. ☐ Other: _____	Quantity: _____ Refills: _____
☐ Simponi ARIA	50 mg/4 mL in a single use vial	Infuse 2 mg/kg over 30 minutes at weeks 0 and 4, then every 8 weeks thereafter.	Quantity: _____ Number of 50 mg vial Refills: _____
☐ Stelara	☐ 45mg/0.5mL prefilled ☐ 90mg/mL prefilled syringe	☐ For patients weighing ≤100 kg (220 lbs): Inject 45 mg SC initially and 4 weeks later, followed by 45 mg every 12 weeks. ☐ For patients weighing >100 kg (220 lbs): Inject 90 mg SC initially and 4 weeks later, followed by 90 mg every 12 weeks. ☐ Other: _____	Quantity: _____ Refills: _____
☐ Taltz	☐ 80 mg Single Dose Autoinjector ☐ 80 mg Single Dose Prefilled Syringe	Psoriasis Dosing: ☐ Starting Dose: Inject SC two 80 mg injections on Day 1, then begin first induction dose 2 weeks later. ☐ Induction Dose: Inject SC one 80 mg injection every 2 weeks (weeks 2-10). ☐ Final Induction Dose: Inject SC one 80 mg injection (week 12). ☐ Maintenance Dose: Inject SC one 80 mg injection every 4 weeks.	Quantity: ☐ 3 Pens/Syringes ☐ 2 Pens/Syringes ☐ 1 Pens/Syringes Refills: _____
☐ Taltz	☐ 80 mg Single Dose Autoinjector ☐ 80 mg Single Dose Prefilled Syringe	Psoriatic Arthritis Dosing: ☐ Starting Dose: Inject SC two 80 mg injections on Day 1. ☐ Maintenance Dose: Inject SC one 80 mg injection every 4 weeks.	Quantity: ☐ 2 Pens/Syringes ☐ 1 Pens/Syringes Refills: _____
☐ Xeljanz	☐ 5 mg Tablet ☐ 11 mg XR Tablet	☐ Take one 5 mg tablet PO twice daily ☐ Take one 11 mg PO once daily ☐ Other: _____	Quantity: _____ Refills: _____

Patient is interested in patient support programs **STAMP SIGNATURE NOT ALLOWED** Ancillary supplies and kits provided as needed for administration

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PRODUCT SUBSTITUTION PERMITTED _____ DATE _____ DISPENSE AS WRITTEN _____ DATE _____

Nursing Medications
Rheumatology Enrollment Form

Please complete Patient and Prescriber Information

Patient Name _____ Patient Date of Birth _____

Prescriber Name _____ Prescriber Phone _____

Complete Items below, required for Home Infusion/Coram AIS:

5 PRESCRIPTION INFORMATION

MEDICATIONS	ROUTE	DOSE & DIRECTIONS	QUANTITY/REFILLS
Catheter ☐ PIV ☐ PICC ☐ PORT	☐ IV	Catheter Care/Flush – Only on drug admin days – SASH or PRN to maintain IV access and patency PIV – NS 5ml (Heparin 10 units/ml 3-5ml if multiple days) PORT/PICC – NS 10ml & Heparin 100units/ml 3-5ml, and/or 10ml sterile saline to access port a cath	Quantity: _____ Refills: _____
☐ Epinephrine **nursing requires**	☐ IM ☐ SC	☐ Adult 1:1000, 0.3mL (>30kg/>66lbs) ☐ Peds 1:2000, 0.3mL (15-30kg/33-66lbs) ☐ Infant 0.1mL/0.1mL, 0.1mL (7.5-15kg/16.5-33lbs) PRN severe allergic reaction – Call 911 May repeat in 5-15 minutes as needed	Quantity: _____ Refills: _____

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PRODUCT SUBSTITUTION PERMITTED _____ DATE _____ DISPENSE AS WRITTEN _____ DATE _____