XUBEX®
Specialty Pharmacy Services
www.Xubex.com

Patient Intake Form-RHEUMATOLOGY

3796 Howell Branch Road • Winter Park, FL 32792
Toll free: 866-699-8239 • Toll free fax 866-495-3304

TODAY'S DATE____________ DATE NEEDED____________

PATIENT INFORMATION

First:	Last:	M.I.:	☐Male ☐ Female	
Date of Birth:	SSN:		Best Phone:	
Address:	City:		State:	Zip:
Shipping Address (if different from home address):			Height:	Weight:

PRESCRIBER INFORMATION

First:	Last:	M.I.:	
DEA#:	Med. Lic. #:	NPI#:	
Office Contact:	Phone:	Alt. Phone:	
Address:	City:	State:	Zip:

INSURANCE INFORMATION (PLEASE FAX COPIES OF FRONT AND BACK OF INSURANCE, PRESCRIPTION AND/OR CO-PAY ASSISTANCE CARDS)

Primary:	PCN:	BIN#	**Secondary:**	PCN:	ID#:
Phone:	ID#:	Group#	Phone:	BIN#	Group#
Prescription Drug Insurer:	Phone:	RxGrp#:		RxBIN#:	PCN/ID#:

CLINICAL INFORMATION

TB Test Results: ☐ Negative ☐ Positive Date______________ | If positive has patient been treated? ☐ Yes ☐ No

Primary Diagnoses: ☐ 714.0 RA ☐ 714.2 ☐ 714.3 Juvenile RA ☐ 714.2 ☐ 696.0 Psoriatic Arthropathy ☐ 714.1 RA+Splenoadenomegaly
☐ 720.0 Ankylosing Spondylitis Other ICD-9______________________

Allergies:

Failed Therapies and Dates:

Current Therapies/Medications:

Will patient stop taking the above medications before starting the new medication? ☐ Yes ☐ No | If yes, what is the washout period?

Does the patient have any co-morbid infections? ☐ Yes ☐ No | # of tender joints_____ # of swollen joints________ | Morning Stiffness ☐ Yes ☐ No

☑ PRESCRIPTION (PLEASE SELECT FROM THE BELOW AND PROVIDE APPROXIMATE DAYS SUPPLY)

Enbrel®
Dosing for RA, Psoriatic Arthritis:
☐ 50mg SC weekly ☐ PFS or ☐ Sureclick
☐ 25mg SC BIW ☐ PFS or ☐ Vial
☐ Other:__________
Qty:______ Refills:_______ ☐ 1Year

Humira®
Dosing for RA, Psoriatic Arthritis:
Humira® 40mg SC every other week
☐ Pen or ☐ PFS
☐ Other:__________________
Qty:______ Refills:_______ ☐ 1Year

Cimzia®
Dosing for RA titration
☐ 400mg SC at 0, 2, 4 weeks then
Maintenance Dose:
☐ 200mg SC every 2 weeks
☐ 400mg SC every 4 weeks
Qty:______ Refills:_______ ☐ 1Year
Dispense In:
☐ 200mg lyophilized vial
☐ 200mg Pre-filled syringe

Remicade® (Must be shipped to MD office)
Remicade® Starting Dose:
____mg/kg IV at 0,2,6 weeks
Remicade® Maintenance Dosing:
____mg/kg IV Q 8 weeks
Qty: ______ Refills: _______ ☐ 1 Year

Orencia® Sub Q 125mg/ml
Orencia® Maintenance Dose
☐ Inject 125mg/ml SC q week #4 refills________

Kineret® Prefilled 100mg Syringe
Inject 100mg (0.67) SQ once daily #28
Qty: ______ Refills: _______ ☐ 1 Year

Simponi®
50mg/0.5ml SC once a month
☐ Pre-filled SmartJet™ AutoJet single dose
☐ Pre-filled syringe single dose
Qty:______ Refills:_______ ☐ 1 Year

Methotrexate
☐ Methotrexate inj 25mg/ml 2ml vial
☐ Methotrexate 2.5mg Tablet
Directions:______________________________
Quantity:_____________________Refill______

Other
Medication Name: __________________
Strength: __________________________
Directions:_________________________
Qty:______ Refills:______ ☐ 1 Year

ADDITIONAL INSTRUCTIONS

Please Deliver To: ☐ Patient's Home ☐ Dr.'s Office ☐ 1st dose to MD's office, remaining refills to patient's home

Physician's Signature: | Date:

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