Mast Specialty Pharmacy

Rheumatology Enrollment Form

PATIENT INFORMATION

Patient Name:_____
Address:_____
City,St,Zip_____
Phone (H) _____ Phone (other)_____
Daite of Birth _____ Gender _____
Primary Language_____

PRESCRIBER INFORMATION

Prescriber's Name_____
DEA#_____ NPI#_____
Group/Hosp _____
Address:_____
City,St,Zip_____
Phone: _____Fax_____
Contact Person:_____

INSURANCE INFORMATION

Carrier Name	BIN#	PCN#	GRP#	ID#	Insured Name

STATEMENT OF MEDICAL NECESSITY

Diagnosis Date of Diagnosis_____

__ 714.0 Rheumatoid Arthritis __ 733.0 Osteoporosis
__ 696.0 Psoriatic Arthritis __ 714.3 Juvenile Idiopathic Arthritis
__ 720.0 Ankylosing Spondylitis

Prior FAILED Medications

Medication	Duration of Treatment/Reason D/C

Allergies

Patient Evaluation

Is patient taking Methotrexate? Y N
Has patient tried and failed 8-12 wks of oral systemic DMARD agents? Y N
Are there contraindications to any Arthritis agents? Y N
If yes, Drug_____ Reason_____
Has patient been diagnosed with Heart Failure? Y N
Has patient been diagnosed with Lymphoma? Y N
Does patient have serious/active infection? Y N
Has TB test been performed? Y N If yes, results _____
Is patient at risk for Hepatitis B infection? Y N
If yes, has Hepatitis B been ruled out or treatment initiated? Y N
Does patient have a latex allergy? Y N
Patient weight _____

Specialty Pharmacy to coordinate injection training necessary? If yes, agency of choice_____
Training not necessary. Date training occurred _____
Reason: ___ MD office trained patient ___ Patient already trained ___ Will use alternative trainer

PRESCRIPTION INFORMATION

DRUG	STRENGTH	DOSE	QTY	REFILLS	DIRECTIONS

_____ _____
Product Substitution Permitted Date Dispense as Written Date

PATIENT AUTHORIZATION

I authorize Mast Drug Co to enroll me in the Specialty Pharmacy program corresponding with my prescribed therapy for purposes of receiving additional services such as, but not limited to, injection training. I further authorize the release to communicate to the corresponding manufacturer the minimum necessary information about my health conditions and prescription(s) to: coordinate the delivery of products and services available through the Specialty Pharmacy program, de-identified data for market analysis and provide educational information regarding therapies. I understand I may revoke this authorization at anytime in writing by sending a letter to Mast Drug Co, 1910 Ross Mill Rd, Henderson, NC 27537. I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment from the pharmacy.

_____
Patient Signature Date