ACRO PHARMACEUTICAL SERVICES
A PREMIER INC. COMPANY
www.acropharmacy.com

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RAASSIST®
ENROLLMENT FORM
(A-M Self-Administered)

Today's Date:_____
Needed By:_____

Last update 12.04.2018

COMMCARE SPECIALTY PHARMACY
A PREMIER INC. COMPANY
www.commcarepharmacy.com

Plantation, FL
Phone: 888.203.7973
Fax: 888.203.7980
NCPDP: 1079638
NPI: 1598762015

Patient Demographics:(Please provide the following or attach demographics sheet)
Patient Name:_____
Address:_____
City, State, Zip:_____
Preferred Phone:_____ Alt. Phone:_____
Last four digits of SS#:_____ Date of Birth:_____
Gender:__ Allergies:_____Height:_____ Weight:_____

Provider Office: (Please provide as much information as possible)
Prescriber's Name:_____ Group/Hospital: _____
Specialty:_____ License#:_____Tax ID#:_____
Address:_____
NPI:_____ DEA:_____
City, State, Zip:_____
Phone:_____ Fax:_____ Office Contact:_____

Insurance Information: (Please copy and attach the front and back of the patient's insurance card)

Medication Delivery to: (choose one) □Patient's Address □Always to Physician's Office □First fill to Physician's Office, refills to Patient's Address

Diagnostic Information: ☐M06.9 Rheumatoid Arthritis ☐L40.59 Psoriatic Arthritis ☐M45.9 Ankylosing Spondylitis ☐Other_____ ☐Other_____

Injection Training: ☐Patient has received injection training ☐Physician's office to provide injection training ☐Specialty Pharmacy to coordinate injection training

Requested Clinical Information: *(as applicable)*
Has Hepatitis B been ruled out? □Yes □No
Has TB test been performed? □Yes □No
Does patient have a latex allergy? □Yes □No
Does patient have serious/active infection? □Yes □No
If Yes, Results _____

Previous Therapies:
_____

DRUG NAME	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐**Actemra**®	☐162mg/0.9 mL prefilled syringe	☐162mg SQ every other week ☐162mg SQ every week	☐4 week supply ☐Other:_____	
☐**Cimzia**®	☐200mg/mL Starter Kit (6 prefilled syringes) ☐200mg/mL (2 prefilled syringes) ☐200mg Lyophilized powder pack (2 vials)	**INITIAL DOSE:** ☐Inject 400mg SQ at weeks 0,2, and 4 **MAINTENANCE DOSE:** ☐Inject 400mg SQ every 4 weeks ☐Inject 200mg SQ every 2 weeks ☐Other_____	**INITIAL DOSE:** ☐Starter kit x 1 ☐Other:_____ **MAINT** ☐4 week supply ☐Other:_____	
☐**Cosentyx**®	☐150mg/mL Sensoready® Pen ☐150mg/mL Prefilled Syringe ☐150mg Single Use Vial	**INITIAL DOSE:** ☐Inject 150mg SQ initially (Weeks 0, 1, 2, 3, and 4) ☐Other_____ **MAINTENANCE DOSE:** ☐Inject 150mg SQ every 4 weeks ☐Other_____	**INITIAL DOSE:** ☐35 day supply ☐Other:_____ **MAINTENANCE DOSE:** ☐4 week supply ☐Other:_____	
☐**Enbrel**®	☐50mg/mL Sureclick Autoinjector ☐50mg/mL Prefilled Syringe ☐25mg/0.5mL Prefilled Syringe ☐25mg Multiple Use Vial ☐50mg/mL Mini Cartridge	☐Inject 50mg SQ ONCE a Week ☐Other_____	☐4 week supply ☐Other:_____	
☐**Humira**®	***Citrate Free*** ☐10mg/0.1mL PFS ☐20mg/0.2mL PFS ☐40mg/0.4mL PEN ☐40mg/0.4mL PFS ***Non-Citrate Free*** ☐10mg/0.2mL PFS ☐20mg/0.4mL PFS ☐40mg/0.8mL PEN ☐40mg/0.8mL PFS	***Adult*** ☐Inject 40mg SQ every OTHER week ☐Other_____ ***Child: 10kg (22lbs) to <15kg (33lbs)*** ☐Inject 10mg SQ every OTHER week ***Child: 15kg (33lbs) to <30kg (66lbs)*** ☐Inject 20mg SQ every OTHER week ***Child: ≥30kg (66lbs)*** ☐Inject 40mg SQ every OTHER week ☐Other_____	☐4 week supply ☐Other:_____	
☐**Kevzara**®	☐150mg/1.14 mL Prefilled Syringe ☐200mg/1.14 mL Prefilled Syringe	☐Inject 200mg SQ every TWO weeks ☐Other_____	☐4 week supply ☐Other:_____ **SQ = subcutaneously**	

Unless otherwise noted this prescription authorizes Acro and Commcare to dispense & share information between each other to optimize care delivery. Check here to restrict to □Acro □Commcare

Physician Signature:_____ ☐DAW (Dispense as Written) **Date:**_____

Patient Support Programs: I authorize **Acro Pharmaceutical Services and Commcare Specialty Pharmacy** to enroll me in company-assisted patient support 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 condition and prescription(s) to: coordinate the delivery of products and services available through the patient assistance program, aggregate de-identified data for market analysis or other commercial purposes, and provide educational information regarding therapies. 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. However, I will not be enrolled in the service program listed above. A copy of this authorization will be utilized with same effectiveness as an original. Ancillary supplies provided as needed for administration.

***Patient Signature:** (required for participation)_____ Date:_____ □ Please select if you would like the patient enrolled in a Manufacturer's Assistance Program