

ACRO
PHARMACEUTICAL SERVICES
A PREMIER INC. COMPANY
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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)		Provider Office: (Please provide as much information as possible)	
Patient Name: _____		Prescriber's Name: _____ Group/Hospital: _____	
Address: _____		Specialty: _____ License#: _____ Tax ID#: _____	
City, State, Zip: _____		Address: _____	
Preferred Phone: _____ Alt. Phone: _____		NPI: _____ DEA: _____	
Last four digits of SS#: _____ Date of Birth: _____		City, State, Zip: _____	
Gender: _____ Allergies: _____ Height: _____ Weight: _____		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) Does patient have a latex allergy? Yes No
Has Hepatitis B been ruled out? Yes No Does patient have serious/active infection? Yes No
Has TB test been performed? Yes No If Yes, Results _____

Previous Therapies:

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

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