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RAASSIST®
ENROLLMENT FORM (N-Z)

Today's Date: _____
 Needed By: _____

Last update 12.04.2018



www.commcarepharmacy.com
 Plantation, FL
 Phone: 888.203.7973
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| | | | |
|--|--|--|--|
| 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 L40.9 Psoriasis M45.9 Ankylosing Spondylitis 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"/> Olumiant® | <input type="checkbox"/> 2mg Tablet | <input type="checkbox"/> 2mg PO ONCE DAILY | <input type="checkbox"/> 30 day supply <input type="checkbox"/> Other: _____ | |
| <input type="checkbox"/> Orencia® | <input type="checkbox"/> 125mg/ml ClickJect Pen <input type="checkbox"/> 125mg/ml Prefilled Syringe <input type="checkbox"/> 87.5mg/0.7ml Prefilled Syringe <input type="checkbox"/> 50mg/0.4ml Prefilled Syringe | <input type="checkbox"/> 125mg SQ ONCE a week <input type="checkbox"/> Other _____ | <input type="checkbox"/> 4 week supply <input type="checkbox"/> Other: _____ | |
| <input type="checkbox"/> Simponi® | <input type="checkbox"/> 50mg / 0.5mL AutoInjector <input type="checkbox"/> 50mg / 0.5mL Prefilled Syringe | <input type="checkbox"/> Inject 50mg SQ ONCE a month <input type="checkbox"/> Other _____ | <input type="checkbox"/> 4 week supply <input type="checkbox"/> Other: _____ | |
| <input type="checkbox"/> Stelara® | <input type="checkbox"/> 45mg/0.5mL Prefilled Syringe <input type="checkbox"/> 45mg/0.5mL Single Use Vial <input type="checkbox"/> 90mg/1 mL Prefilled Syringe <input type="checkbox"/> 90mg/1 mL Single Use Vial | <i>Patients with weight ≤ 100kg</i> <input type="checkbox"/> INITIAL: Inject 45 mg SQ initially (week 0) & 4 weeks later <input type="checkbox"/> MAINTENANCE: Inject 45 mg SQ every 12 weeks <i>Patients with weight > 100kg</i> <input type="checkbox"/> INITIAL: Inject 90 mg SQ initially (week 0) & 4 weeks later <input type="checkbox"/> MAINTENANCE: Inject 90 mg SQ every 12 weeks | INITIAL: # ___ syringe/vial MAINTENANCE: <input type="checkbox"/> 12 week supply <input type="checkbox"/> Other _____ | |
| <input type="checkbox"/> Taltz® | <input type="checkbox"/> 80 mg/1 mL Autoinjector <input type="checkbox"/> 80 mg/1 mL Prefilled Syringe | Active Psoriatic Arthritis: Does not have Moderate to Severe Psoriasis | INITIAL: 2 pens/syringes | 0 |
| | | <input type="checkbox"/> INITIAL: Inject 160mg (2 x 80mg) SQ on day 1 | MAINTENANCE: 1 pen/syringes | |
| | | <input type="checkbox"/> MAINTENANCE: Inject 1 x 80mg SQ every 4 weeks | | |
| | | Moderate to Severe Psoriasis: With or without Active Psoriatic Arthritis | INITIAL: 3 pens/syringes | 0 |
| <input type="checkbox"/> Xeljanz® | <input type="checkbox"/> 5mg Tablet | <input type="checkbox"/> INITIAL: Inject 160mg (2 x 80mg) SQ on day 1, then begin first induction dose (1 x 80mg) 2 weeks later (week 2) | INDUCTION: 2 pens/syringes | 1 |
| | | <input type="checkbox"/> INDUCTION: Inject 1 x 80mg SQ every 2 weeks (weeks 4-10) | FINAL INDUCTION: 1 pen/syringes | 0 |
| | | <input type="checkbox"/> FINAL INDUCTION: Inject 1 x 80mg SQ (week 12) | MAINTENANCE: 1 pen/syringes | |
| <input type="checkbox"/> MAINTENANCE: Inject 1 x 80mg SQ every 4 weeks | | | | |
| <input type="checkbox"/> Xeljanz XR® | <input type="checkbox"/> 11mg Tablet | <input type="checkbox"/> 11mg PO ONCE DAILY <input type="checkbox"/> Other _____ | <input type="checkbox"/> 30 day supply <input type="checkbox"/> Other: _____ | |
| <input type="checkbox"/> Other | | | <input type="checkbox"/> PO = by mouth <input type="checkbox"/> 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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