ACRO PHARMACEUTICAL SERVICES
A PREMIER INC. COMPANY

www.acropharmacy.com

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RAASSIST®
ENROLLMENT FORM (N-Z)

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 ☐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)*
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
☐**Olumiant®**	☐2mg Tablet	☐2mg PO ONCE DAILY	☐30 day supply ☐Other:_____	
☐**Orencia®**	☐125mg/ml ClickJect Pen ☐125mg/ml Prefilled Syringe ☐87.5mg/0.7ml Prefilled Syringe ☐50mg/0.4ml Prefilled Syringe	☐125mg SQ ONCE a week ☐Other_____	☐4 week supply ☐Other:_____	
☐**Simponi®**	☐50mg / 0.5mL AutoInjector ☐50mg / 0.5mL Prefilled Syringe	☐Inject 50mg SQ ONCE a month ☐Other_____	☐4 week supply ☐Other:_____	
☐**Stelara®**	☐45mg/0.5mL Prefilled Syringe ☐45mg/0.5mL Single Use Vial ☐90mg/1 mL Prefilled Syringe ☐90mg/1 mL Single Use Vial	*Patients with weight ≤ 100kg* ☐**INITIAL:** Inject 45 mg SQ initially (week 0) & 4 weeks later ☐**MAINTENANCE:** Inject 45 mg SQ every 12 weeks *Patients with weight > 100kg* ☐**INITIAL:** Inject 90 mg SQ initially (week 0) & 4 weeks later ☐**MAINTENANCE:** Inject 90 mg SQ every 12 weeks	**INITIAL:** # ___syringe/vial **MAINTENANCE:** ☐12 week supply ☐Other_____	
☐**Taltz®**	☐80 mg/1 mL Autoinjector ☐80 mg/1 mL Prefilled Syringe	***Active Psoriatic Arthritis: Does not have Moderate to Severe Psoriasis*** ☐**INITIAL:** Inject 160mg (2 x 80mg) SQ on day 1 ☐**MAINTENANCE:** Inject 1 x 80mg SQ every 4 weeks ***Moderate to Severe Psoriasis: With or without Active Psoriatic Arthritis*** ☐**INITIAL:** Inject 160mg (2 x 80mg) SQ on day 1, then begin first induction dose (1 x 80mg) 2 weeks later (week 2) ☐**INDUCTION:** Inject 1 x 80mg SQ every 2 weeks (weeks 4-10) ☐**FINAL INDUCTION:** Inject 1 x 80mg SQ (week 12) ☐**MAINTENANCE:** Inject 1 x 80mg SQ every 4 weeks	**INITIAL:** 2 pens/syringes **MAINTENANCE:** 1 pen/syringes **INITIAL:** 3 pens/syringes **INDUCTION:** 2 pens/syringes **FINAL INDUCTION:** 1 pen/syringes **MAINTENANCE:** 1 pen/syringes	**0** **0** **1** **0**
☐**Xeljanz®**	☐5mg Tablet	☐5mg PO BID ☐Other_____	☐30 day supply ☐Other:_____	
☐**Xeljanz XR®**	☐11mg Tablet	☐11mg PO ONCE DAILY ☐Other_____	☐30 day supply ☐Other:_____	
☐**Other**			**PO = by mouth** **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