



Phone: 1-888-899-7447
Fax: 1-866-368-9808

CAP Rheumatology Patient Order Form

PATIENT INFORMATION

Patient Name		<input type="checkbox"/> Male <input type="checkbox"/> Female	Allergies		<input type="checkbox"/> NKDA
Date of Birth		SSN#	Weight _____ <input type="checkbox"/> kg <input type="checkbox"/> lb Date		
Address		City	State	Zip	
Phone # (Home)	(Work)	Email address (optional)			

INSURANCE INFORMATION (PLEASE ATTACH A PHOTOCOPY OF THE FRONT AND BACK OF ALL INSURANCE CARDS)

Primary Insurance		Medicare ID	
Group #	Policy #	Phone #	
Secondary Insurance	Policy #	Phone #	

MEDICATION HISTORY

Please indicate which of the following the patient has tried previously:
 Humira Orencia Enbrel Rituxan Remicade Kineret Other _____ None of these

Is the patient currently on methotrexate therapy? YES NO

PRIMARY DIAGNOSIS AND DATE OF DIAGNOSIS	SECONDARY DIAGNOSIS
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<input type="checkbox"/> 714.0 Rheumatoid Arthritis <input type="checkbox"/> 714.3 Juvenile Idiopathic Arthritis <input type="checkbox"/> 555.____ Crohn's Disease <input type="checkbox"/> 556.____ Ulcerative Colitis	<input type="checkbox"/> 696.0 Psoriatic Arthropathy <input type="checkbox"/> 696.1 Other Psoriasis <input type="checkbox"/> 720.0 Ankylosing Spondylitis <input type="checkbox"/> Other ICD 9 _____
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Year of Primary Diagnosis: _____

PRESCRIPTION INFORMATION

Medication	Dose	Directions/Frequency of Administration	Total # Doses
<input type="checkbox"/> Methotrexate	_____mg		
<input type="checkbox"/> Orencia® (abatacept)	<input type="checkbox"/> 500 mg <input type="checkbox"/> 750 mg <input type="checkbox"/> 1 gram <input type="checkbox"/> _____mg	<input type="checkbox"/> IV @ 0 weeks (induction) <input type="checkbox"/> IV @ 2 weeks (induction) <input type="checkbox"/> IV @ 4 weeks (induction) <input type="checkbox"/> IV every 4 weeks (maintenance) <input type="checkbox"/> IV every _____ weeks	
<input type="checkbox"/> Remicade® (Infliximab)	<input type="checkbox"/> 3 mg/kg <input type="checkbox"/> 5 mg/kg <input type="checkbox"/> _____mg/kg (Please fill in weight section)	<input type="checkbox"/> IV @ 0 weeks (induction) <input type="checkbox"/> IV @ 2 weeks (induction) <input type="checkbox"/> IV @ 6 weeks (induction) <input type="checkbox"/> IV every 8 weeks (maintenance) <input type="checkbox"/> IV every _____ weeks	
<input type="checkbox"/> Rituxan® (Rituximab)	10 mg/mL in a 50 mL vial (500 mg)	<input type="checkbox"/> Infuse 1000 mg IV and follow with a second dose of 1000 mg IV in 2 weeks <input type="checkbox"/> _____	
<input type="checkbox"/> Other:			

DELIVERY INSTRUCTIONS

Order will be shipped to the address provided below. Physician must be registered with CAP at this location and this must be the site of administration.	Administration Date * (date of infusion)
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PHYSICIAN CONTACT INFORMATION & AUTHORIZATION

Physician Name	Office Contact	Institution
Phone	Fax	Specialty
Address		City/State/Zip
DEA #	UPIN #	
CAP PIN #	NPI #	

Physician's Signature _____ **Date** _____
 (required to process prescription – stamped signatures are not permissible)

***If this order is needed in less than 48 hours please call 888-899-7447 to place order. R (3/08)**