MORRISTOWN PHARMACY

RA & INFLAMMATION PRESCRIPTION FORM

95 Madison Ave #110 | Morristown, NJ, 07960
Tel : 973 - 998 - 0287 | Fax : 973 - 998 - 0288

Proudly serving New Jersey, New York, Pennsylvania, Ohio, Massachusetts, Arizona & Rhode Island

Today's Date _____ Anticipated Start Date _____

☐ NEW PATIENT ☐ CURRENT PATIENT

Last updated: May 2017

Patient Name First Name Middle Name Last Name DOB _____ Weight _____ ☐ Male ☐ Female

Street Address _____ Apt # _____ City _____ State _____ Zip _____

Daytime Tel _____ Evening Tel _____ Cell _____ Email _____

Ship to Patient at ☐ Home ☐ Work **OR** Patient will pick up at ☐ Physician Office ☐ Pharmacy Date Needed _____

ICD-10 Code ☐ M06.9 Rheumatoid Arthritis ☐ L40.59 Psoriatic Arthritis ☐ M45.9 Ankylosing Spondylitis PPD (TB Test) _____ Chest X-ray _____ Date of Labs _____

☐ Rheumatoid Factor + Total Swollen Joints _____ Previously treated ☐ No ☐ Yes, what drugs ☐ Corticosteroids ☐ Methotrexate ☐ Humira ☐ Enbrel Other _____

Insured's Name _____ Relation to Patient _____ Eligible for Medicare ☐ Yes ☐ No If yes, Medicare# _____

Prescription Card ☐ Yes ☐ No If Yes, Carrier _____ Tel _____ Fax _____ Policy/Group# _____

Bin# _____ Pcn# _____ RXID# _____ RX Group# _____

Prescriber's Name _____ Office Contact _____

Street Address _____ Suite # _____ City _____ State _____ Zip _____

Tel _____ Fax _____ Email _____

License# _____ NPI# _____ UPIN# _____ DEA# _____

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

OTEZLA® (apremilast)
☐ Titration Starter Pack SIG: Take as directed QTY: 55 for 28 days
☐ Maintenance: 30 mg SIG: Take 30mg twice a day QTY: 60 Refills ____

CIMZIA® (certolizumab pegol)
☐ **Initial Dose:** 400mg (two 200mg subcutaneous injections) at wks 0, 2 & 4 (Starter Kit #6) Qty: 1 Kit
☐ **Maintenance Dose:** 200mg subcutaneous injection every other week Qty: 28 Day Supply
Other _____ Refill x _____

ENBREL® ☐ 50 mg ☐ 25 mg | ☐ *SureClick™* ☐ Prefilled Syringe ☐ Multiuse Vial
Dispense/Sig: ☐ 1 x week ☐ 2 x week Qty: 28 Day Supply Refill x _____

STELARA **Starting Dose:** ☐ 45 mg ☐ 90mg SQ initially & weeks 4 later
Maintenance Dose: ☐ 45 mg ☐ 90mg SQ every 12 weeks

ORENCIA® ☐ 125 mg PFS ☐ 250 mg VIAL ☐ 125 mg ClickJect™ (Carton of 4 Autoinjectors)
☐ Qty: 28 day Refill x _____
☐ 250mg Vial (IV use only) Loading Dose: 10mg/kg IV x 1 dose, then 125mg SC weekly, start within 24hrs of IV dose, 1 dose, 4 week supply

HUMIRA® (adalimumab) **Dose:** ☐ 40mg/0.8mL PFS ☐ 40mg/0.8mL Pens
Patient weight (kg) _____ Qty: 28 Day Supply Refill x _____
Dispense/Sig: ☐ Inject 40mg subcutaneously every other week

FORTEO® (#1 pen) ☐ Inject 20mg SQ Daily Qty 1pen w/30 needles Refill x _____
PEN NEEDLES ☐ 31 gauge-6mm *use with forteo as directed* Qty #30 Refill x _____

SIMPONI ® (golimumab) inject 50mg subcutaneously once per month
Dose: *SureJect™* ☐ 50mg/0.5mL | Prefilled Syringe ☐ 50mg/0.5mL QTY: 1 Refill x _____
SIMPONI ARIA® ☐ 50 mg/4 mL (12.5 mg/mL) in a single use vial QTY: 1 Refill x _____
SIG: 2 mg/kg intravenous infusion over 30 minutes at weeks 0 and 4, then every 8 weeks

COSENTYX - PSORIATIC ARTHRITIS & ANKYLOSING SPONDYLITIS
New York Prescribers, please submit prescription on an original NY State prescription blank.
With Loading Dose ☐ Sensoready® Pen ☐ Prefilled Syringe
Weeks 0, 1, 2, 3, and 4, then once every 4 weeks
SIG: ☐ Inject 150 mg dose SQ once weekly for 5 weeks QTY: 10 injection devices Refills: 0

Without Loading Dose ☐ Sensoready® Pen ☐ Prefilled Syringe
SIG: ☐ Inject 150 mg dose SQ once every 4 weeks
☐ 1 Month ☐ 2 Months ☐ 3 Months QTY: _____ Refills: _____

ACTEMRA® (tocilizumab) Prefilled-Syringe QTY _____ Refills _____
☐ Inject 162mg subcutaneously every other week (pt wt<100kg)
☐ Inject 162mg subcutaneously every week (pt wt >100kg or per clinical response)
ACTEMRA IV _____mg Q4W (every 4 weeks) Adult (IV) Dosage
starting dose is 4 mg per kg every 4 weeks followed by an increase to 8 mg per kg every 4 weeks based on clinical response QTY _____ Refills _____

XELJANZ ® (tofacitinib citrate) 5mg tablet
Sig _____ Qty _____ Refills _____

☐ **ENROLL IN NURSE TRAINING / MANUFACTURER PROGRAM**

Prescriber's Signature (signature required. NO STAMPS) _____ **Date** _____