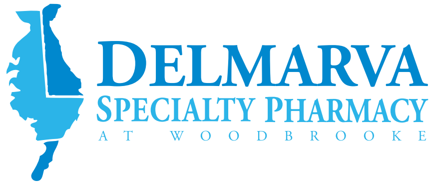

RA & INFLAMMATION PRESCRIPTION FORM

1615 Tree Sap Court Salisbury, MD 21804
Tel 410.677.0561 Fax 410.677.0562

Today's Date

☐ NEW PATIENT ☐ CURRENT PATIENT

Dec 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 Diagnosis ________ PPD (TB Test) ________ Chest X-ray ________ Date of Labs ________

☐ Rheumatoid Factor Positive Total Swollen Joints ________ Previously treated ☐ Yes ☐ No If yes, what drugs ________

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

TALTZ 80mg ☐ Autoinjector ☐ Prefilled Syringe
Psoriatic Arthritis Start Dose: ☐ 160 mg SQ at wk 0, followed by 80 mg every 4 wks QTY: 2 Refills: ____
Maintenance: ☐ Inject 80mg SQ every 4 weeks QTY: ____ Refills: ____
☐ Other: ________ QTY: ____ Refills: ____

CIMZIA® (certolizumab pegol)
Initial Dose: ☐ 400mg (two 200mg subcutaneous injections) at weeks 0, 2 & 4 (Starter Kit #6)
Maint. Dose: ☐ 200mg subcutaneous injection every other week Qty ____ Refills ____
☐ Other ________ Qty ____ Refills ____

ENBREL® (etanercept)
Dose: Prefilled Syringe ☐ 25mg ☐ 50mg | Multiuse Vial ☐ 25mg | *SureClick™* ☐ 50mg
Dispense: ☐ 1 x week ☐ 2 x week Qty ________ Refills ________

HUMIRA® (adalimumab)
Dose: ☐ 40mg/0.8mL PFS ☐ 40mg/0.8mL Pens ☐ 20mg/0.4mL PFS.
Patient weight (kg) ________
Dispense: ☐ Inject 40mg subcutaneously every other week
Juvenile Arthritis
☐ Patient weight 15kg to < 30kg inject 20mg subcutaneously every other week
☐ Patient weight > 30kg inject 40mg subcutaneously every other week
Qty ________ Refills ________

SIMPONI ® (golimumab) inject 50mg subcutaneously once per month
Dose: *SmartJect™* ☐ 50mg/0.5mL | Prefilled Syringe ☐ 50mg/0.5mL

FORTEO ® Pen (#1 pen) ☐ Inject 20mcg SQ Daily Refills ________

KINERET ® (anakinra) ☐ Inject ____ mg SQ every day 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)

XELJANZ® (tofacitinib citrate) ☐ 5 mg tablet
Rheumatoid Arthritis ☐ 5 mg twice daily.
Psoriatic Arthritis ☐ 5 mg twice daily, used in combination with nonbiologic DMARDs
Sig ________ Qty ________ Refills ________

XELJANZ XR® (tofacitinib citrate) ☐ 11 mg tablet
Rheumatoid Arthritis ☐ 11 mg once daily
Psoriatic Arthritis ☐ 11 mg once daily, used in combination with nonbiologic DMARDs
Sig ________ Qty ________ Refills ________

OTHER ________
Sig ________ Qty ____ Refills ____

By signing this form and utilizing our services, you are authorizing Delmarva Specialty and it's employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

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

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