RA & INFLAMMATION PRESCRIPTION FORM

DELMARVA SPECIALTY PHARMACY AT WOODBROOKE

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

Today's Date

☐ NEW PATIENT ☐ CURRENT PATIENT

June 2018

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

OLUMIANT (baricitinib)
SIG: ☐ 2 mg PO once daily with or without food QTY: 30 Refills: _____

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) Patient weight (kg) _____
Dose: ☐ 40mg/0.8mL PFS ☐ 40mg/0.8mL Pens ☐ 20mg/0.4mL PFS.
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** _____

Please fax completed referral form to **Delmarva Specialty Pharmacy** at **410.677.0562** Visit us at **WWW.DELMARVAPHARMACY.COM** for online fillable forms.