RA & INFLAMMATION PRESCRIPTION FORM

151 Cochituate Rd | Framingham, MA 01701
Ph 508.202.9993 | 844.7.MYVCARE | Fx 508.202.9343

Today's Date

☐ NEW PATIENT ☐ CURRENT PATIENT

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 ☐ V-Care 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

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

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

SIMPONI ARIA® ☐ 50mg/4mL vial Qty ________ (vials) Refills ________
Infuse _____mg (2mg/kg) IV over 30 minutes at weeks 0 and 4, then every 8 weeks

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

KINERET ® (anakinra) ☐ Inject ______ mg subcutaneously every day
Qty ________ Refills ________

ORENCIA® ☐ Inject 125mg subcutaneously weekly 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

ACTEMRA® (tocilizumab) Prefilled-Syringe
☐ Inject 162mg subcutaneously every other week (pt wt<100kg)
☐ Inject 162mg subcutaneously every week (pt wt >100kg or per clinical response)
QTY ________ Refills ________

XELJANZ® (tofacitinib citrate) 5mg tablet Sig ________Qty ______ Refills ______

By signing this form and utilizing our services, you are authorizing V-Care Pharmacy 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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