V-Care Pharmacy
Specialty + Medical & Surgical Supplies

RA & INFLAMMATION PRESCRIPTION FORM

151 Cochituate Rd | Framingham, MA 01701
Ph 508.202.9993 | 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

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

XELJANZ® ☐ 5 mg tablet **XELJANZ XR®** ☐ 11 mg tablet
Rheumatoid Arthritis ☐ 5 mg twice daily ☐ 11 mg once daily
Psoriatic Arthritis ☐ 5 mg twice daily, used in combination with nonbiologic DMARDs
☐ 11 mg once daily, used in combination with nonbiologic DMARDs
☐ Other: QTY Refills

KEVZARA® (sarilumab) ☐ 200 mg/1.14 mL single dose PFS | ☐ 150 mg/1.14 mL single dose PFS
Dispense: ☐ Inject 150 mg subcutaneously once every two weeks QTY: 2 Refills
☐ Inject 200 mg subcutaneously once every two weeks QTY: 2 Refills

RASUVO AutoInjector
Dose: ☐ 7.5 mg ☐ 15 mg ☐ 22.5 mg ☐ 30 mg ☐ 10 mg
☐ 17.5 mg ☐ 25 mg ☐ 12.5 mg ☐ 20 mg ☐ 27.5 mg
SIG ☐ Inject _____ mg subcutaneously every week QTY: 4

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 QTY Refills
☐ Patient weight > 30kg inject 40mg subcutaneously every other week QTY Refills

SIMPONI® (golimumab) inject 50mg subcutaneously once per month
Dose: *SureJect™* ☐ 50mg/0.5mL | Prefilled Syringe ☐ 50mg/0.5mL QTY: 1 Refills
SIMPONI ARIA® ☐ 50 mg/4 mL (12.5 mg/mL) in a single use vial QTY: 1 Refills
SIG: 2 mg/kg intravenous infusion 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 Refills
☐ 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

CIMZIA® (certolizumab pegol)
☐ **Initial Dose:** 400mg (two 200mg subcutaneous injections) at weeks 0, 2 & 4 (Starter Kit #6) Qty: 1 Kit
☐ **Maintenance Dose:** 200mg subcutaneous injection every other week Qty: 28 Day Supply
☐ Other 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 QTY Refills
starting dose is 4 mg/kg every 4 wks followed by an increase to 8 mg/kg every 4 weeks based on clinical response

ENBREL® ☐ 50 mg ☐ 25 mg | ☐ *SureClick™* ☐ PFS ☐ Multiuse Vial ☐ Enbrel Mini™/AutoTouch
Dispense/Sig: ☐ 1 x week ☐ 2 x week QTY: 28 Day Supply 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**

Please fax completed referral form to **V-Care Pharmacy & Surgical Supplies** at **508.202.9343** Visit us at **WWW.MYVCAREPHARMACY.COM** for online fillable forms.