V-CARE PHARMACY

RA & INFLAMMATION PRESCRIPTION REFERRAL FORM

151 Cochituate Rd | Framingham, MA 01701
PHONE: 508-202-9993 | FAX: 508-202-9343 | 844-7-MYVCARE

☐ NEW PATIENT ☐ CURRENT PATIENT

Patient Name _____ D.O.B _____ Weight _____ ☐ Male ☐ Female

Address _____ City _____ State _____ Zip _____

Daytime Telephone _____ Evening Telephone _____ 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, which 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: ____

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

KEVZARA®(arilumab) ☐ 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 ☐ 10 mg ☐ 12.5 mg ☐ 15 mg ☐ 17.5 mg
☐ 20 mg ☐ 22.5 mg ☐ 25 mg ☐ 27.5 mg ☐ 30 mg
SIG ☐ Inject _____ mg subcutaneously every week QTY: 4

HUMIRA®(adalimumab) Patient Weight (kg) _____
Dose: ☐ 40 mg/0.8mL PFS ☐ 40 mg/0.8mL Pens ☐ 20 mg/0.4mL PFS
Dispense: ☐ Inject 40 mg 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*™ 50 mg/0.5mL ☐ Prefilled Syringe 50 mg/0.5 mL QTY: ____ Refills: ____
SIMPONI ARIA® ☐ 50 mg/4 mL (12.5 mg/mL) in a single use vial QTY: ____ Refills: ____
SIG: 2 mg/kg intravenous infusion over 30 minutes at weeks 0 an d 4, then every 8 weeks

SIMPONI® Pen (#1 pen) ☐ Inject 20mcg SQ Daily Refills: ____
KINERET® (anakinra) ☐ Inject ____ mg subcutaneously every day QTY: ____ Refills: ____
ORENCIA® ☐ Inject 125 mg subcutaneously weekly QTY: ____ Refills: ____
☐ 250 mg Vial (IV use only) Loading Dose: 10 mg/kg IV x 1 dose, then 125 mg SC weekly, start within 24hrs of IV dose, 1 dose, 4 week supply

CIMZIA® (certolizumab pegol)
☐ Initial Dose: 400 mg (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: ____

This is **not** a valid prescription and is intended for reference only. For providers: **Please send a valid prescription electronically or via fax.**

Prescriber's Signature (no stamps) _____ **Date** _____