

RA & INFLAMMATION PRESCRIPTION FORM

54 Conchester Road Glen Mills, PA 19342
 1-866-317-0672 TEL: 610-545-6040 FAX: 610-545-6030

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 Pharmacy Date Needed _____
 ICD-9 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: *SureJect™* 50mg/0.5mL | Prefilled Syringe 50mg/0.5mL
FORTEO® Pen (#1 pen) Inject 20mg SQ Daily Refills _____
KINERET® (anakinra) Inject 100mg subcutaneously every day
 Qty _____ Refills _____

OTHER _____
 Sig _____
 Qty _____ Refills _____
OTHER _____
 Sig _____
 Qty _____ Refills _____

By signing this form and utilizing our services, you are authorizing Elwyn 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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