RA & INFLAMMATION PRESCRIPTION FORM

1070 Springfield Ave, Irvington, NJ 07111
Phone : 862-255-2804 | Fax : 860-229-2417
E-mail : irvingtonpharmacy@gmail.com

Today's Date

☐ NEW PATIENT ☐ CURRENT PATIENT

Patient 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 Code Allergies CD4 Viral Load

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) Qty 1 Kit
☐ **Maintenance Dose:** 200mg subcutaneous injection every other week Qty 28 Day Supply
Other_______________ Refill x_______

ENBREL (etanercept)
Dose: Prefilled Syringe ☐ 25mg ☐ 50mg Multiuse Vial ☐ 25mg SureClick ☐ 50mg
Dispense: ☐ 1 x week ☐ 2 x week Qty 28 Day Supply Refill x_______

HUMIRA (adalimumab)
Dose: ☐ 40mg/0.8mL PFS ☐ 40mg/0.8mL Pens ☐ 20mg/0.4mL PFS.
Patient weight (kg)_______ Qty 28 Day Supply Refill x_______
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 28 Day Supply Refill x_______

PROLIA (osteoporosis 733.01)
☐ PRE-MEDICATIONS Administer APAP 500 – 1000mg PO and Benadryl 25mg PO prn
RX --- PROLIA (DENOSUMAB) 60MG ONCE EVERY SIX MONTHS Qty #1 Refill x_______

SIMPONI (golimumab) inject 50mg subcutaneously once per month
Dose: SureJect ☐ 50mg/0.5mL | Prefilled Syringe ☐ 50mg/0.5mL QTY: 1 Refill x_______
SIMPONI ARIA ☐ 50 mg/4 mL (12.5 mg/mL) in a single use vial QTY: 1 Refill x_______
SIG: 2 mg/kg intravenous infusion over 30 minutes at weeks 0 and 4, then every 8 weeks

FORTEO (#1 pen) ☐ Inject 20mg SQ Daily Qty 1pen w/30 needles Refill x_______
PEN NEEDLES ☐ 31 gauge-6mm use with forteo as directed Qty #30 Refill x_______
KINERET (anakinra) ☐ Inject 100mg subcutaneously daily Qty_______ Refill x_______
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

XELJANZ (tofacitinib citrate) 5mg tablet Sig_______ 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)
ACTEMRA IV_______mg Q4W (every 4 weeks) Adult (IV) Dosage
☐ starting dose is 4 mg per kg every 4 weeks followed by an increase to 8 mg per kg every 4 weeks based on clinical response

Prescriber's Signature signature required. NO STAMPS) Date

IMPORTANT NOTICE::This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.
PLEASE NOTE: Riverfront Pharmacy can only accept original prescription drug orders from patients, faxed prescriptions can be accepted only from the prescribing practitioners.