

RA & INFLAMMATION PRESCRIPTION FORM

3070 McCann Farm Drive | Suite 101 | Garnet Valley, PA 19060
 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-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
 Other _____ Qty _____ Refills _____

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 wt (kg) _____
Dispense: Inject 40mg subcutaneously every other week Qty _____ Refills _____
Juvenile Arthritis
 Patient weight 15kg to < 30kg inject 20mg subcutaneously every other week
 Patient weight > 30kg inject 40mg subcutaneously every other week

REMICADE 100 mg vial MD Office Infusion Home Infusion
 Infusion supplies needed: YES NO
 Starting Dose: _____mg/kg _____mg on week 0, week 2 & week 6 then,
 Maintenance Dose: _____mg/kg _____mg every 8 weeks for _____ infusions every 8 weeks
 Other _____ 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

XELJANZ® (tofacitinib citrate) 5mg tablet Sig _____ Qty _____ Refills _____

STELARA Starting Dose: 45 mg 90mg SQ initially & weeks 4 later
 Maintenance Dose: 45 mg 90mg SQ every 12 weeks

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** _____

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.



NEW REFERRAL CHECKLIST

PLEASE USE THIS CHECKLIST FOR PATIENTS WITH RHEUMATOID ARTHRITIS

Please use the attached checklist as a reference in order to provide the proper documentation to process the required prior authorization for your patient's treatment.

All lab reports (or EMR) must contain the following information within the last 30 days.

Please forward any updates to us you receive from the insurance company regarding approvals or denials

REQUIRED INFORMATION:

- Patient name
- Patient Demographics (Address, Phone Number, DOB, etc...)
- Medication list and allergies
- Insurance information with RX insurance. Please include copy of card.

If the only card included is a medical card, please include local pharmacy information.

- MD name/NPI/Office contact/Phone number
- Drug indicated with refills
- MD signature and date on referral form
- Recent TB test results and date
- Previous treatment
- Symptoms
- Clinical notes

Fax the requested documentation to (610) 545-6030

Toll Free: 1-855-ELWYN-RX (359-9679) Direct Phone: (610) 545-6040

ElwynSpecialtyCare.com

Elwyn
SPECIALTY CARE
Part of The Elwyn Pharmacy Group
Dedicated to Improving
Our Patients' Health

