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

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** _____

Please fax completed referral form to **Elwyn Specialty Care** at **610-545-6030** Visit us at **WWW.ELWYNSPECIALTYCARE.COM** for online fillable forms.

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

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