RA & Inflammation Prescription Referral Form

Phone: 732-885-1000 **Fax: 732-980-0357**

10 Plainfield Ave., Suite 1, Piscataway, New Jersey 08854 www.carepointpharmacynj.com

Complete Patient Demographic Information in Section Below OR Attach Face Sheet from Patient Chart

First Name	*Middle Initial*	*Last Name*	*Date of Birth*	*Gender* ◯ M ◯ F	*Social Security Number*

Street:

City	*State*	*Zip Code*	*Home Phone*	*Work Phone*	*Cell Phone*

Complete Patient Insurance Information in Section Below OR Attach Copies of Patient Insurance Card

Insurance Carrier Name - Primary	*Name of Insured*	*Relationship*	*ID#*	*Group Number*	*Insurance Phone*
Rx-Carrier Name -Secondary	*Rx ID#*	*Rx Group #*	*Rx Phone #*		

Complete Drug Therapy Information in Section Below OR Attach Completed Prescription

Drug Name	Form/Strength/Directions for Use	Qty	Refills
Cimzia	☐ **Starting dose :** 400mg SC at 0, 2, 4 weeks then ☐ **On going** 200mg SC every other week ☐ 400 mg SQ every 4 weeks ☐ 200mg lyophilized vial ☐ 200mg Pre-filled syringe		
Enbrel	☐ 50 mg SQ weekly ☐ PFS or ☐ Sureclick ☐ 25 mg SQ BIW ☐ Other: ______ ☐ 1year		
Humira	**Starting dose:** ☐ 80mg SQ x one initial dose then ☐ 40mg SQ every other week starting one week after initial dose Dispense in starter package for initial dosing **Maintenance dosing:** ☐ 40 mg SQ every other week ☐ Pen or ☐ PFS ☐ 40 mg SQ once a week ☐ Pen or ☐ PFS		
Otezla	☐ Therapy Initiation Titration Pack - Take as Directed ☐ 30mg twice a day ☐ 30mg once a day (Patients with Severe Renal Impairment)		
Simponi	☐ 50 mg/0.5 ml SC once a month ☐ Pre - filled SmartJet™ ☐ Pre - filled syringe single dose		
Stelara Ship to ☐ MDO ☐ Patient	**Initial Dosing:** ☐ 45mg PFS SQ x1 followed by 45mg PFS SQ in 4 weeks(For patients weighting < 100kg) ☐ 90 mg PFS SQ x1 followed by 90mg PFS SQ in 4 weeks (For patients weighting > 100kg **Ongoing Dosing:** ☐ 45mg PFS SQ every 12 weeks ☐ 45mg PFS SQ every 12 weeks		
Tecfidera	☐ Initial dose: Titration Pack : 8.8 mcg SC TIW x 2 weeks, Then 22 mcg SC TIW x 2 weeks ☐ Ongoing Treatment: 44 mcg SC TIW ☐ 22 mcg SC TIW ☐ 1year ☐ Other: ____________		
Remicade	☐ mg/kg IV at 0, 2, 6 Weeks → ☐ mg/kg IV Q 8 Weeks ☐ mg/kg IV Q 8 Weeks ☐ Other: ____________		
XELJANZ	☐ 5mg PO Twice a day		

Information Needed to Obtain Prior Authorizations

Primary Diagnosis: ☐ Rheumatoid Arthritis, ICD - 10 ☐ Psoriatic Arthritis. ICD - 10 ☐ Other: Weight

Allergies:

Failed Therapies: ☐ Methotrexate ☐ Humira ☐ other

Please provide current list of medications:

Complete Prescriber Information in Section Below NOT Included on Attached Prescription

MD First Name	*MD Last Name*	*DEA #*	*UPIN*	*State License #*	*NPI*

Office Address:			
City:		State:	Zip:
Office		Office Fax:	
Office Contact Name:		Office E-mail:	

SIGNATURE OF LICENSED PRESCRIBER IS REQUIRED TO VALIDATE PRESCRIPTIONS

☐ *I authorize Carepoint Pharmacy to initiate a Prior Authorization on my behalf.* TLC/JS 9/15/15

Dr: *Substitution Permitted*	**Dr:** *No Substitution Permitted*	**Date:**