

# BERGEN AVE DRUGS RA & INFLAMMATION PRESCRIPTION FORM

## Specialty Pharmacy

745 Bergen Ave | Jersey City, NJ, 07306

Tel 201.521.0545 | Fax 201.521.0546

Today's Date

Anticipated Start Date

NEW PATIENT

CURRENT PATIENT

Proudly serving New Jersey, New York, Pennsylvania, Ohio, Massachusetts, Arizona & Rhode Island

Last updated: May 2017

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 Code  M06.9 Rheumatoid Arthritis  L40.59 Psoriatic Arthritis  M45.9 Ankylosing Spondylitis PPD (TB Test) \_\_\_\_\_ Chest X-ray \_\_\_\_\_ Date of Labs \_\_\_\_\_

Rheumatoid Factor + Total Swollen Joints \_\_\_\_\_ Previously treated  No  Yes, what drugs  Corticosteroids  Methotrexate  Humira  Enbrel Other \_\_\_\_\_

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

**OTEZLA®** (apremilast)  
 Titration Starter Pack SIG: Take as directed QTY: 55 for 28 days  
 Maintenance: 30 mg SIG: Take 30mg twice a day QTY: 60 Refills \_\_\_\_\_

**CIMZIA®** (certalizumab pegol)  
 **Initial Dose:** 400mg (two 200mg subcutaneous injections) at wks 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®**  50 mg  25 mg |  SureClick™  Prefilled Syringe  Multiuse Vial  
**Dispense/Sig:**  1 x week  2 x week Qty: 28 Day Supply Refill x \_\_\_\_\_

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

**ORENCIA®**  125 mg PFS  250 mg VIAL  125 mg ClickJect™ (Carton of 4 Autoinjectors)  
 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

**HUMIRA®** (adalimumab) **Dose:**  40mg/0.8mL PFS  40mg/0.8mL Pens  
Patient weight (kg) \_\_\_\_\_ Qty: 28 Day Supply Refill x \_\_\_\_\_  
**Dispense/Sig:**  Inject 40mg subcutaneously every other week

**FORTEO®** (#1 pen)  Inject 20mg SQ Daily Qty 1 pen w/30 needles Refill x \_\_\_\_\_  
**PEN NEEDLES**  31 gauge-6mm use with forteo as directed Qty #30 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

**COSENTYX - PSORIATIC ARTHRITIS & ANKYLOSING SPONDYLITIS**  
*New York Prescribers, please submit prescription on an original NY State prescription blank.*  
**With Loading Dose**  Sensoready® Pen  Prefilled Syringe  
Weeks 0, 1, 2, 3, and 4, then once every 4 weeks  
SIG:  Inject 150 mg dose SQ once weekly for 5 weeks QTY: 10 injection devices Refills: 0  
**Without Loading Dose**  Sensoready® Pen  Prefilled Syringe  
SIG:  Inject 150 mg dose SQ once every 4 weeks  
 1 Month  2 Months  3 Months 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 QTY \_\_\_\_\_ Refills \_\_\_\_\_

**XELJANZ®** (tofacitinib citrate) 5mg tablet  
Sig \_\_\_\_\_ Qty \_\_\_\_\_ Refills \_\_\_\_\_

**ENROLL IN NURSE TRAINING / MANUFACTURER PROGRAM**

**Prescriber's Signature** (signature required. NO STAMPS) \_\_\_\_\_ **Date** \_\_\_\_\_

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