ST.JUDE
SPECIALTY PHARMACY
& MEDICAL SUPPLIES

RA & INFLAMMATION PRESCRIPTION FORM

121 St. Nicholas Ave Brooklyn, NY 11237
TEL: 718-381-5116 FAX: 718-417-3621
Proudly serving over 30 years

Today's Date | Anticipated Start 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-9 Code ☐ 714.0 Rheumatoid Arthritis ☐ 696.0 Psoriatic Arthritis ☐ 720.0 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** QTY _____ Refills_____
Directions: Day 1: 10mg in AM Day 4: 20mg in AM; 20mg in PM
Day 2: 10mg in AM; 10mg in PM Day 5: 20mg in AM; 30mg in PM
Day 3: 10mg in AM; 20mg in PM Day 6,thereafter: 30mg twice daily

CIMZIA® (certolizumab 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® **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

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

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