Padek Healthcare
Quality Care From The Pharmacists You Trust
PHARMACY

Padek Healthcare RA & Inflammation Prescription Form

5403 A Annapolis Rd Bladensburg, MD 20710
Tel 301-277-7107 | Fax 301-277-7127

Today's Date

☐ NEW PATIENT ☐ CURRENT PATIENT

Patient Name _____ DOB _____ Weight _____ ☐ Male ☐ Female
Street Address _____ Apt # _____ City _____ State _____ Zip _____
Evening 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 SC injections) at weeks 0, 2 & 4 (Starter Kit #6)
Maintenance Dose: ☐ 200mg SC injection every other week Qty _____ Refills _____
☐ Other _____

ENBREL® (etanercept)
Dose: Prefilled Syringe ☐ 25mg ☐ 50mg | Multiuse Vial ☐ 25mg | *SureClick™* ☐ 50mg
Dispense: ☐ 1 x week ☐ 2 x week Qty _____ Refills _____

OTEZLA® ☐ Titration Starter Pack ☐ Tablets
Dose: ☐ Take as directed **These directions can only be selected for the Titration Starter Pack** Qty 27 Refills ____
☐ Take 30 mg once daily Qty 30 Refills ____
☐ Take 30 mg twice daily Qty 60 Refills ____

HUMIRA® (adalimumab)
Dose: ☐ 40mg/0.8mL PFS ☐ 40mg/0.8mL Pens
☐ Inject 40mg subcutaneously every other week Qty _____ Refills _____

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

ACTEMRA® (tocilizumab) Prefilled-Syringe
☐ Inject 162mg SC every other week (pt wt<100kg)
☐ Inject 162mg SC every week (pt wt >100kg or per clinical response) Qty _____ Refills _____

COSENTYX ☐ Sensoready® Pen ☐ Prefilled Syringe
Starting Dose *Weeks 0, 1, 2, 3, and 4, then once every 4 weeks*
SIG: ☐ Inject 300 mg dose SQ once weekly for 5 wks ***Each 300 mg dose is given as 2 SQ injections of 150 mg***
QTY: 10 injection devices Refills: 0
Maintenance Supply *Once every 4 weeks*
SIG: ☐ Inject 300 mg dose SQ once every 4 weeks ***Each 300 mg dose is given as 2 SQ injections of 150 mg***
☐ Other: _____
☐ 1 Month ☐ 2 Months ☐ 3 Months QTY: _____ Refills: _____

SIMPONI ® (golimumab) inject 50mg subcutaneously once per month
Dose: *SmartJect™* ☐ 50mg/0.5mL | Prefilled Syringe ☐ 50mg/0.5mL

FORTEO ® Pen (#1 pen) ☐ Inject 20mcg SQ Daily Refills _____

KINERET ® (anakinra) ☐ Inject _____ mg subcutaneously every day
Qty _____ Refills _____

ORENCIA® ☐ 125mg PFS ☐ 250mg VIAL ☐ 125mg ClickJect™ (Carton of 4 Autoinjectors)
SIG: ☐ Inject 125mg SC weekly
☐ 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
Qty 28 day Refill x _____

OTHER MEDICATION
Other _____ Dose _____ Refill x _____ Sig _____

By signing this form and utilizing our services, you are authorizing Padek Healthcare 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 PADEK HEALTHCARE AT 301-277-7127