TruCare PHARMACY
Phone: (844) 446-0808 | Fax: (844) 446-0809

RHEUMATOID ARTHRITIS PRESCRIPTION FORM

Ship To: ☐ Patient ☐ Physician ☐ Pick-up (store location)

Patient Name:(Required) DOB:		Physician Name:	
Home Phone: Cell Phone:		LIC#: DEA #:	NPI #:
Address:		Practice Name/Hospital:	
City: State: Zip:		Address:	
Emergency Contact Name/Phone #:(Required)		City: State: Zip:	
Patient Soc. Sec #:	Allergies: ☐ NKA	Physician's Phone:	Physician's Fax:
Height: BSA: m²	Sex: ☐ M ☐ F Weight: ☐ lbs. ☐ Kg	Specialty:	Office Contact:

INSURANCE INFORMATION | Please Attach Demographics and Copies (front and back) of Insurance cards

DIAGNOSIS INFORMATION (choose one) | Please FAX clinical notes, Labs, Tests with the prescription

Diagnosis: _____ Other: _____

Prior failed medications (medication and duration of treatment/reason for d/c):_____

Is patient currently on RA therapy? ☐ Yes ☐ No Medications: _____ Does patient have a latex allergy? ☐ Yes ☐ No

TB/PPD test given? ☐ Yes ☐ No BMD/T-score: _____ Date:_____

Is patient at risk for osteoporotic fracture as evident by any of the following? History of osteoporotic fracture Site: _____ Date:_____

Patient has tried and failed an oral bisphosphonate: ☐ Yes ☐ No Patient has documented contraindications/is intolerant to oral bisphosphonate therapy: ☐ Yes ☐ No (please submit a copy of DEXA w/prescription)

PRESCRIPTION INFORMATION | Xeljanz NOT to be used in combination with biologic DMARD's

	STRENGTH	DIRECTIONS	QTY	REFILLS
☐ **ENBREL®**	☐ 50mg/ml SureClick™ Autoinjector ☐ 50mg/ml Prefilled Syringe ☐ 25mg/0.5ml Prefilled Syringe	☐ Inject 50mg SC ONCE a week ☐ Inject 25mg TWICE a week, 72 to 96 hours apart ☐ Other _____	4-week supply	
☐ **FORTEO®**	600mcg/2.4ml Prefilled Syringe	Inject 20mcg SC, as directed, once daily	4-week supply	
☐ **Pen Needles**	31 gauge 6mm		28 needles	
☐ **HUMIRA®** Injection training from My Humira (patient must sign below)	☐ 40mg/0.8ml Pen ☐ 40mg/0.8ml Prefilled Syringe	☐ Inject 40mg SC every OTHER week ☐ Inject 40mg SC ONCE a week	4-week supply	
☐ **OTEZLA®**				
☐ **PROLIA®**	60mg Prefilled Syringe	Inject 60mg SC ONCE every 6 months		
☐ **SIMPONI®**	☐ 50mg/0.5ml Prefilled Syringe ☐ 50mg/0.5ml Autoinjector	Inject 50mg ONCE a month	4-week supply	
☐ **RITUXAN®**	☐ _____mg (375 mg/m²) IV in 500mL NS weekly for 4 weeks ☐ _____mg (375 mg/m² **or** _____mg/m²) IV in 500mL NS q_____days (Please circle or indicate desired dose) ☐ 1000 mg IV in NS (1 mg/mL) on Days 1 and 15.			
☐ **COSENTYX™**	☐ 150 mg/mL Prefilled Syringes ☐ 150 mg/ml Sensoready® pen ☐ 150 mg vial of lophilized powder (Sensoready® pen will be dispensed if no preference indicated)	☐ Starting Dose: 300 mg SQ initially (weeks 0, 1, 2, 3 and 4), then 300 mg SQ every 4 weeks thereafter (week 4) ☐ Maintenance Dose: 300 mg SQ every 4 weeks ☐ Other _____	☐ 5 ☐ 1	
☐ **STELARA™**	≤ 100kg ☐ Starting Dose: 45 mg SQ initially (week 0), then 45 mg SQ after 4 weeks of initial dose (week 4) ☐ Maintenance Dose: 45 mg SQ every 12 weeks ☐ Other _____		☐ 1 ☐ 1	
☐ **Pre-Filled Syringe** ☐ **Vial**	> 100kg ☐ Starting Dose: 90 mg SQ initially (week 0), then 90 mg SQ after 4 weeks of initial dose (week 4) ☐ Maintenance Dose: 90 mg SQ every 12 weeks ☐ Other _____		☐ 1 ☐ 1	
☐ **CIMZIA®**	☐ Prefilled Syringes (2 x 200mg) ☐ Lyophilized vials (2 x 200mg)	☐ Induction Dose: Inject 400mg SC at weeks 0,2 and 4 ☐ Maintenance Dose: 400mg SC every 4 weeks		
☐ **BENLYSTA®**	☐ 120mg/mL vial ☐ 400mg/mL vial	☐ Induction Dose: Inject 10mg/kg SC every 2 weeks for 3 doses. ☐ Maintenance Dose: 10mg/kg SC every 4 weeks		
☐ **ORENCIA®**	☐ 125 mg/mL Prefilled Syringes ☐ 125 mg/mL ClickJect™ Autoinjector ☐ 250 mg/mL of lophilized powder (Sensoready® pen will be dispensed if no preference indicated)	☐ Starting Dose: Inject 125mg SC ONCE a week ☐ Maintenance Dose: 125mg SQ at weeks 2 and 4, then every 4 weeks ☐ Other _____	☐ 5 ☐ 1	
☐ **XELJANZ®** ☐ **XELJANZ XR®**	☐ 5mg Tablet ☐ 11mg Tablet	☐ Induction Dose: 5mg Tab twice daily ☐ Maintenance Dose: 11mg tab once daily following last initial dose		
☐ **OTHER**				

PRE-MEDICATION

☐ **Acetaminophen 650mg PO 30-60 minutes pre-rituximab**	☐ **Diphenhydramine 50 mg PO/IV 30-60 minutes pre-rituximab**

PATIENT SUPPORT PROGRAMS: Please sign and date below to enroll in pharmaceutical company assisted patient support program

Patient Signature: _____ Date: _____

# of Medications Prescribed: _____

Physician's Signature: _____ ☐ **DAW (Dispense as Written)** **Date:** _____