RA & INFLAMMATION PRESCRIPTION FORM

1299 McCarter Hwy Newark, NJ 07104
Tel 973-485-8522 Fax: 973-485-8570
Only servicing patients residing in the state of New Jersey

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

CIMZIA® (certolizumab pegol)
☐ Initial Dose: 400mg (two 200mg subcutaneous injections) at weeks 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® (etanercept)
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
Juvenile Arthritis
☐ Patient weight 15kg to < 30kg inject 20mg subcutaneously every other week
☐ Patient weight > 30kg inject 40mg subcutaneously every other week
Qty 28 Day Supply Refill x

PROLIA (osteoporosis 733.01)
____ PRE-MEDICATIONS Administer APAP 500 – 1000mg PO and Benadryl 25mg PO prn
RX --- PROLIA (DENOSUMAB) 60MG ONCE EVERY SIX MONTHS Qty #1 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

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

By signing this form and utilizing our services, you are authorizing Giannotto's 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

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