



P: 832-813-8932

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REFILLS

1 YEAR

\_\_\_\_\_

# ENDOCRINOLOGY RX FORM

## PATIENT INFORMATION

PATIENT NAME: \_\_\_\_\_ DOB \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ PHONE: (\_\_\_\_) - \_\_\_\_\_ - \_\_\_\_\_

\*PLEASE ATTACH A COPY OF THE PATIENT'S INSURANCE INFORMATION AND DEMOGRAPHICS\*

## MEDICATION

## PRE-MEDICATIONS

- BENYLSTA 10MG/KG IV ON DAY 0, DAY 14, AND DAY 28
- BENLYSTA 10MG/KG IV EVERY 28 DAYS  
\*PREMEDICATE: SOLUMEDROL 100MG IV 30 MIN PRIOR  
BENADRYL 25MG PO, TYLENOL 1000MG PO
- KRSTEXXA 8MG IV EVERY 2 WEEKS  
\*PREMEDICATIONS MUST BE SELECTED
- RECLAST 5MG/100ML IV FOR ONE DOSE YEARLY
- PROLIA 60MG SQ EVERY 6 MONTHS
- EVENITY 210MG SQ EVERY MONTH FOR 12 MONTHS
- ELAPRASE 0.5MG/KG IV EVERY WEEK  
\*PREMEDICATE: TYLENOL 1000MG PO, BENADRYL 25MG PO  
TO BE GIVEN 30 MIN PRIOR TO INFUSION
- FABRAZYME 1MG/KG IV EVERY 2 WEEKS  
\*PREMEDICATE: SOLUMEDROL 100MG IV 30 MIN PRIOR  
BENADRYL 25MG PO, TYLENOL 1000MG PO

- BENADRYL IV \_\_\_\_\_ MG
- REGLAN IV \_\_\_\_\_ MG
- SOLUMEDROL IV \_\_\_\_\_ MG
- ZOFRAN IV \_\_\_\_\_ MG
- OTHER IV \_\_\_\_\_ MG
- VITAMINS IV (SPECIFY DOSE): \_\_\_\_\_
- BENADRYL PO \_\_\_\_\_ MG
- TYLENOL PO \_\_\_\_\_ MG
- ZYRTEC PO \_\_\_\_\_ MG
- ZOFRAN PO \_\_\_\_\_ MG
- ZANTAC PO \_\_\_\_\_ MG
- OTHER PO \_\_\_\_\_ MG

IF APPLICABLE, DATE OF LAST INFUSION: \_\_\_\_\_

## MEDICAL INFORMATION

WEIGHT: \_\_\_\_\_ LBS HEIGHT: \_\_\_\_\_ IN  
 ALLERGIES: \_\_\_\_\_  N.K.D.A  
 DATE OF LAST ANA TEST (BENLYSTA): \_\_\_\_\_  
 DATE OF sUA LEVEL (KRSTEXXA): \_\_\_\_\_  
 LEVEL: \_\_\_\_\_ MG/DL  
 DATE OF eGFR (KRSTEXXA): \_\_\_\_\_  
 LEVEL: \_\_\_\_\_

### PREVIOUSLY FAILED MEDICATIONS/DOSE:

#1 \_\_\_\_\_ DATE RANGE: \_\_\_\_\_  
 #2 \_\_\_\_\_ DATE RANGE: \_\_\_\_\_  
 #3 \_\_\_\_\_ DATE RANGE: \_\_\_\_\_

\*PLEASE ATTACH ALL MEDICAL RECORDS, INCLUDING LAB WORK, CLINICAL NOTES, HOSPITALIZATION RECORDS, OR SURGICAL PROCEDURES\*

## DIAGNOSIS

DIAGNOSIS: \_\_\_\_\_ ICD-10: \_\_\_\_\_

## PHYSICIAN INFORMATION

*By signing this form and utilizing our services, you are authorizing our company (based on preferred location) and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.*

PHYSICIAN NAME (PRINTED): \_\_\_\_\_ NPI: \_\_\_\_\_

PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_ CONTACT PERSON: \_\_\_\_\_

PHYSICIAN NAME (SIGNED): \_\_\_\_\_ DATE: \_\_\_\_\_

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