P: 832-813-8932

F: 888-883-9901

ENDOCRINOLOGY RX FORM

REFILLS
☐ 1 YEAR
☐ _____

PATIENT INFORMATION

PATIENT NAME: _____ **DOB** _____/_____/_____ **PHONE:** (_____) - _____ - _____

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

MEDICATION

☐ 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

☐ KRYSTEXXA 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

PRE-MEDICATIONS

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 (KRYSTEXXA): _____
LEVEL: _____ **MG/DL**

DATE OF eGFR (KRYSTEXXA): _____
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:** _____