P: 832-813-8932

F: 888-883-9901

RHEUMATOLOGY RX FORM

REFILLS
☐ 1 YEAR
☐ _____

PATIENT INFORMATION

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

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

MEDICATION

☐ CIMZIA 400MG SQ AT WEEKS 0, 2, 4 AND EVERY 4 WEEKS
☐ CIMZIA _____ MG SQ EVERY _____ WEEKS

☐ ORENCIA _____MG IV AT WEEKS 0, 2, 4, AND EVERY 4 WEEKS
☐ ORENCIA _____MG IV EVERY 4 WEEKS

☐ REMICADE _____MG/KG IV AT WEEKS 0, 2, 6, AND EVERY 8 WEEKS
☐ REMICADE _____MG/KG IV EVERY _____ WEEKS
*PREMEDICATE: TYLENOL 500MG PO, ZYRTEC 10MG PO

☐ ACTEMRA 4MG/KG IV EVERY 4 WEEKS
☐ ACTEMRA 8MG/KG IV EVERY 4 WEEKS

☐ RITUXAN 1000MG IV EVERY 6 MONTHS AT WEEKS 0 AND 2
*PREMEDICATE: SOLUMEDROL 100MG IV, TYLENOL 500MG PO, BENADRYL 25MG PO (30 MIN PRIOR)

☐ SIMPONI ARIA 2MG/KG IV AT WEEKS 0, 4, AND THEN EVERY 8 WEEKS
☐ SIMPONI ARIA 2MG/KG IV EVERY 8 WEEKS

PRE-MEDICATIONS

BENADRYL IV _____ MG
REGLAN IV _____ MG
SOLUMEDROL IV _____ MG
ZOFRAN IV _____ MG
OTHER IV_____ MG

BENADRYL PO _____ MG
TYLENOL PO _____ MG
ZYRTEC PO _____ MG
ZOFRAN PO _____ MG
ZANTAC PO _____ MG
OTHER PO_____ MG

IF APPLICABLE, DATE OF LAST INFUSION: _____

WILL PATIENT BE RE-LOADING? ☐ **YES** ☐ **NO**

MEDICAL INFORMATION

WEIGHT: _____**LBS** **HEIGHT:** _____ **IN**

ALLERGIES: _____ ☐ **N.K.D.A**

DATE OF TB EXAM (ACTEMRA, ORENCIA, REMICADE, RITUXAN, SimpA): _____
METHOD: ☐ **CXR** ☐ **QFT** ☐ **PPD**
RESULT: ☐ **NEGATIVE** ☐ **POSITIVE**

DATE OF HEP PANEL (ACTEMRA, ORENCIA, RITUXAN, REMICADE, SimpA): _____
RESULT: ☐ **NEGATIVE** ☐ **POSITIVE**

DATE OF CBC W/ DIFF PANEL (ACTEMRA): _____

DATE OF CBC W/ PLATELET (RITUXAN): _____

PREVIOUSLY FAILED MEDICATIONS/DOSE:

#1_____ **DATE RANGE:** _____
#2_____ **DATE RANGE:** _____
#3_____ **DATE RANGE:** _____

PATIENT WILL BE DISCONTINUING: _____

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

DIAGNOSIS

☐ M05.2 _____ RHEUMATOID VASCULITIS W/ RA
☐ M05.3 _____ RHEUMATOID HEART DIS W/ RA
☐ M05.4 _____RHEUMATOID MYOPATHY W/ RA
☐ M05.5 _____RHEUMATOID POLYNEUROPATHY W/ RA
☐ M05.6 _____RA W/ INVOLVEMENT OF OTHER ORGANS AND SYSTEMS

OTHER DX: _____

☐ M05.7 _____RA W/ RHEUMATOID FACTOR W/O ORGANS AND SYSTEMS
☐ M05.8 _____ OTHER RA W/ RHEUMATOID FACTOR
☐ M05.9 RA WITH RHEUMATOID FACTOR, UNSPECIFIED
☐ M06.0 _____ RA W/O RHEUMATOID FACTOR
☐ M06.1 ADULT ONSET STILL'S DISEASE
☐ M06.2 _____ RHEUMATOID BURSITIS
☐ M06.3 _____ RHEUMATOID NODULE
☐ M06.9 RA, UNSPECIFIED

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:** _____