Specialty Care Rx

RHEUMATOLOGY Order Form

Toll Free Fax 833.794.4844
myscrx.com

Specialty Care Rx Representative:

Patient Information

(Please complete the following or fax the patient demographic sheet)

Patient's Name: | Patient's Phone: | DOB: | Zip:

Allergies: | Height [in]: | Weight [lbs]:

Additional Items Faxed: ☐ Demographics ☐ CBC/CMP Results ☐ TB Test Result ☐ HepB Test Result

Any Tried & Failed Products? | Diagnosis ICD-10*

New to Therapy? ☐ Yes ☐ No | Previous Dose Date: | Next Dose Date:

Prescription

CIMZIA SubQ

Dose: ☐ 400mg SubQ (2 × 200 mg injections) ☐ Other: _____mg
Load Frequency: ☐ Week 0, 2, & 4 ☐ Other: _____
Maintenance Dose & Freq: ☐ 200mg Q2W ☐ 400mg Q4W ☐ Other: _____mg
Other: _____

SIMPONI ARIA IV

Loading Dose: ☐ 2mg / kg ☐ _____mg / kg
Load Frequency: ☐ Week 0 ☐ Week 4 ☐ Other: _____
Maintenance Dose: ☐ 2mg / kg ☐ _____mg / kg
Maintenance Freq: ☐ Q8W ☐ Other: _____

IMMUNE GLOBULIN

☐ SubQ ☐ IV
Product: ☐ Pharmacist to determine ☐ Brand: _____
Dose: _____ gm/kg OVER _____day(s) EVERY _____week(s)
Other: _____

STELARA

Dose: ☐ 45mg SubQ (≤100kg) ☐ 90mg SubQ (>100kg)
Load Frequency: ☐ Week 0, 4 ☐ Other: _____
Maintenance Freq: ☐ Q12W ☐ Other: _____
Other: _____

REMICADE

☐ May round dose to nearest 100mg vial ☐ Biosimilar Authorized
Dose: ☐ 3mg/kg ☐ 5mg/kg ☐ 7.5mg/kg ☐ 10mg/kg ☐ _____mg/kg
Load Frequency: ☐ Week 0, 2, & 6 ☐ Other: _____
Maintenance Frequency: ☐ Q4W ☐ Q6W ☐ Q8W ☐ Other: _____

TERIPARATIDE

Dose: ☐ 20mcg SubQ ☐ Other: _____
Frequency: ☐ Once Daily ☐ Other: _____
Other: _____

RITUXAN IV | TRUXIMA IV

Product: ☐ Pharmacist to determine ☐ Rituxan IV ☐ Truxima IV
Dose: ☐ 500mg ☐ 1000mg ☐ Other: _____mg
Freq: ☐ Loading Every _____ Week(s) and Repeat FOR _____Month(s)
☐ Maintenance Every _____Week(s) & Repeat EVERY _____Month(s)

TREMFYA SubQ

Loading Dose: ☐ 100mg ☐ Other: _____mg
Load Frequency: ☐ Week 0, 4 ☐ Other: _____
Maintenance Dose: ☐ 100mg ☐ Other: _____mg
Maintenance Freq: ☐ Q8W ☐ Other: _____

OTHER

Drug: _____ **Freq:** _____
Dose: _____ **Other:** _____
Refills: 1 x Year OR: _____

Orders

Infusion Rate: ☐ Pharmacist to determine
☐ Start at: _____ mL/hr, then increase by: _____ mL/hr, every _____ minutes to max rate _____ mL/hr
Access (IV Only): ☐ Peripheral ☐ PICC ☐ Port ☐ Other: _____
Flushing (IV Only): ☐ Sodium Chloride 0.9% 5-15 mL pre and post medications, ☐ Heparin ☐ 10 Units/mL ☐ 100 Units/mL OR ☐ _____ mL as needed
Pre-Treatment: Acetaminophen & Diphenhydramine included by default ☐ Aspirin 325 mg po ☐ Methylprednisolone ☐ 40mg ☐ 125mg IV ☐ None ☐ Other: _____
Adverse/ Anaphylactic Reactions: Per pharmacy protocol, anaphylaxis kit will be provided if needed

Deliver to: ☐ Home ☐ Infusion Suite ☐ Other: _____

Ancillary Supplies: As needed for proper administration and disposal of medication
Skilled Nursing: As needed for IV access, administration, and proper clinical monitoring
Administration: Procedures to be followed per specialty pharmacy protocol

Physician Information

Physician's Name: | Office Contact (Required):

Address: | City, State, Zip:

Phone: | Fax: | NPI:

Physician's Signature: (No Stamps) | **Date:** (Required)

By signing this form and utilizing our services, you are authorizing SpecialtyCare Rx and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

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