DeliverIt Pharmacy Infusion & Specialty

Address: 12144 Dairy Ashford Rd., Suite 100,
Sugar Land, TX 77478

F: 832.939.8128 T: 832.939.8137

Rheumatology Infusion Orders

PATIENT INFORMATION

Patient Name: ______________________________ Social Sec #: ____________ Weight: ____ lbs

D.O.B: ____________ Sex: Male ____ Female _____ Height: ____ lbs

Phone: __________________

Address: ____ City: __________ State: ____ Zip Code: __________

INSURANCE INFORMATION: PLEASE ATTACH COPY OF PRESCRIPTION/MEDICAL CARD(S), FRONT AND BACK

MEDICAL INFORMATION

- ☐ M 06.9 Rheumatoid arthritis, unspecified
- ☐ M 08.00 Unspecified juvenile rheumatoid arthritis of unspecified site
- ☐ M 08.3 Juvenile rheumatoid polyarthritis (seronegative)
- ☐ M 45.9 Ankylosing spondylitis of unspecified sites in spine
- ☐ L 40.59 Other Psoriatic Anthropathy Description ____________
- ☐ Other Diagnosis: ICD-10 Code _________

Date of Diagnosis ______________

Has a TB test been performed? ☐ Yes ☐ No

Allergies ____________________

Lab Data ____________________

Prior Therapies ____________________

Concomitant Medications ____________________

Additional Comments ____________________

Injection Training Required ☐ Yes ☐ No

Does the patient have an active infection? ☐ Yes ☐ No

Start Date ____________ Review Date ____________

INFUSION ORDERS

MEDICATION	Dose/Strength	Directions	Qty	Refills
☐Acterma	☐ 162mg/0.9ml Autoinjector ☐ 162mg/0.9ml Pre-filled Syringe ☐ 80 mg/4mL Vial ☐ 200 mg/10mL Vial ☐ 400 mg/20mL Vial			
☐Benlysta	☐ 120mg Vial ☐ 400mg Vial ☐ 200 mg/mL Autoinjector ☐ 200 mg/mL Prefilled Syringe			
☐Cimzia	☐ 200 mg/mL Vial Kit ☐ 200 mg/mL Starter Kit ☐ 200 mg/mL Prefilled Syringe			
☐Cosentyx	☐ 200 mg/mL Vial Kit ☐ 200 mg/mL Starter Kit ☐ 150 mg/mL Prefilled Syringe ☐ 150 mg/mL (300 mg dose) Prefilled Syringe			
☐Enbrel	☐ 50 mg/mL SureClick Autoinjector ☐ 50 mg/mL Prefilled Syringe ☐ Enbrel Mini 50 mg/mL Cartridge ☐ 25 mg/0.5 mL Prefilled Syringe ☐ 25 mg Vial			
☐Humira	☐ 10 mg/0.2 mL Prefilled Syringe ☐ 10 mg/0.1 mL Prefilled Syringe (citrate-free) ☐ 20 mg/0.4 mL Prefilled Syringe ☐ 20 mg/0.2 mL Prefilled Syringe (citrate-free) ☐ 40 mg/0.8 mL Prefilled Syringe ☐ 40 mg/0.4 mL Prefilled Syringe (citrate-free) ☐ 40 mg/0.8 mL Pen ☐ 40 mg/0.4 mL Pen (citrate-free)			
☐Inflectra	☐ 100 mg Vial			
☐Kevzara	☐ 150 mg/1.14 mL Prefilled Pen ☐ 200 mg/1.14 mL Prefilled Pen ☐ 150 mg/1.14 mL Prefilled Syringe ☐ 200 mg/1.14 mL Prefilled Syringe			
☐Olumiant	☐ 2 mg Tablet			
☐Orencia	☐ 250 mg Vial ☐ 125 mg/mL Prefilled Syringe ☐ 125 mg/mL ClickJet Autoinjector ☐ 87.5 mg/0.7 mL Prefilled Syringe ☐ 50 mg/0.4 mL ClickJet Autoinjector			
☐Otezla	☐ 30 mg Tablet ☐ Starter Pack (28-day) ☐ Starter Pack (2 weeks)			

INFUSION ORDERS

DIAGNOSIS	Dose/Strength	Directions	Qty	Refills
☐Remicade	☐ 100 mg Vial			
☐Renflexis	☐ 100 mg Vial			
☐Rituxan	☐ 100 mg/10 mL Vial ☐ 500 mg/50 mL Vial			
☐Simponi	☐ 50 mg/0.5 mL Prefilled Syringe ☐ 100 mg/mL Prefilled Syringe ☐ 100 mg/mL SmartJect Autoinjector ☐ 50 mg/0.5 mL SmartJect Autoinjector			
☐Simponi Aria	☐ 50 mg/4 mL Vial			
☐Stelara	☐ 45 mg/0.5 mL Vial ☐ 90 mg/mL Prefilled Syringe ☐ 45 mg/0.5 mL Prefilled Syringe			
☐Taltz	☐ 80 mg/mL Autoinjector ☐ 80 mg/mL Prefilled Syringe			
☐Xeljanz	☐ 5 mg Tablet			
☐Xeljanz XR	☐ 11 mg Extended-Release Tablet			
☐Other				
	Hypersensitivity/Anaphylaxis Response Protocol PRN			

PHYSICIAN INFORMATION

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

Physician Signature: ______________________________ Date: ____________________

Physician Name: ______________________________

Phone: ______________ Fax: ______________ Contact Person: ____________________