IV Rheumatology Order Form

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www.transcriptpharmacy.com

Patient Information

Patient name ____________________

Address ____________________

City ____________ State ______ Zip ______

Home phone ____________ Cell ____________

DOB ____________ SSN ____________

Drug allergies ____________ ❍Male ❍Female

Prescriber Information

Prescriber name ____________ Lic# ______

DEA# ____________ Tax ID ____________

Practice name ____________________

Address ____________ Suite ______

City ____________ State ______ Zip ______

Office Phone ____________ Fax ____________

Insurance, Medicare or Medicaid Information

Primary Insurance ____________________

Policy # ____________ Group ____________

Insurance phone ____________________

Secondary Insurance(*If applicable*,) ____________________

Policy # ____________ Group ____________

Insurance phone ____________________

Prescription Drug Coverage: Company ____________________ Phone ____________

RXGRP# ____________ RXBIN# ____________ PCN/ID# (if avail.) ____________

COMPLETE OR FAX FRONT AND BACK COPIES OF INSURANCE , PRESCRIPTION AND/OR CO-PAY ASSISTANCE CARD(S)

Clinical Information

Primary diagnosis ____________ ICD-9 ______ Patient weight ______ lbs or kgs (please circle) TB/PPD test given? ❍Yes ❍ No

Prior Treatments: ❍ 5-ASA ❍Azathioprine ❍Azulfidine ❍Celebrex ❍Corticosteroids ❍Gold Salts ❍Immunosuppressants ❍ MTX ❍NSAIDS ❍Penicillamine ❍Plaquenil

❍Previous biologic ____________ ❍Other ____________________

Additional medical justification ____________________

Currently on a biologic? ❍Yes ❍No How long? ______ Date of last dose ___/___/___ This Rx is: ❍New therapy ❍Continuing previous treatment on this agent

Drug Name	Prescription Orders (PLEASE CHECK ONE OR MORE)	Quantity	Refills
❍ Actemra (tocilizumab).	Infuse ______mg once every 4 wks Dispense: ❍ 80mg vials ❍200mg vials ❍400mg vials	30day supply	Refills
❍ Orencia (abatacept)	Induction dose: ______mg at weeks 0,2 and 4 Maintenance dose: ________ every 4 weeks thereafter	30 day supply	Refills
❍ Remicade (infliximab)	Induction dose: ______mg at weeks 0, 2 and 6 Maintenance dose: ________mg every 6 weeks thereafter	30 day supply	Refills
❍ Rituxan (rituximab)	Infuse ______mg on Day 1 and Day 15 Dispense: ❍100mg vials ❍ 500mg vials	30 day supply	Refills
Other medication	Directions	Qty	Refills
Other medication	Directions	Qty	Refills

Deliver to: ❍ Patient's home ❍MD's office ❍ Other: ____________________

We authorize Transcript Pharmacy, its employees and agents to assist with delegated prior authorization requests to the fullest extent allowable by law and insurer guidelines.

____________ Prescriber signature

____________ Office contact name (Nurse, MA, Other)

____________ Preferred phone & ext.

____________ Date