Specialty Injection Order Form
Rheumatology / Dermatology

61 Doctor's Park • Cape Girardeau, MO 63703
866-936-1999 • Fax (573) 335-7233

Prescriber's Name: ____________________ MD / DO / NP / PA
Address: ____________________
City ____________ State ________ Zip ________
Office Contact: ________ Phone# ________ Fax# ________
NPI: ________ DEA: ________ License: ________

PATIENT INFORMATION

Send updates to ❑ Fax ❑ E-mail to ____________ ❑ Text to Phone# ________

Patient's Name: ____________________ SS# ____________ DOB: ________
Address: ____________________ City ____________ State ________ Zip ________
Home Phone: ____________ Work or Cell: ____________ Emergency Contact: ____________
Allergies: ____________ Sex: M___ F___ Wt: ________ Ht: ________ Diabetic: Y N
Patient previously on treatment: Y N Date: ____________
Primary Insurance: ____________ Policy# ____________
Insured: ____________ Group ____________
Phone: ____________ BIN# ____________ PCN# ____________

*** Please include current patient medication list with referral ***

STATEMENT OF MEDICAL NECESSITY

PRIMARY DIAGNOSIS: (ICD-9 CM Code Plus Description) Date of Diagnosis: ____________

- ❑ 714.0 Rheumatoid Arthritis
- ❑ 714.30 Arthritis-Rheumatoid, juvenile
- ❑ 696.0 Psoriatic Arthritis
- ❑ 720.0 Ankylosing Spondylitis
- ❑ 696.1 Psoriasis, Other
- ❑ ______ Other____________

Date of onset of symptoms ____________

TB Status: ❑Active TB ❑PPD (-) date: ❑last CXR date: ❑unknown
DNR Status: ❑Rc'd ❑N/A
Did patient receive other medical therapies in the last 6 mos.? ❑No ❑Yes, Date:

Medical History:
- ❑ Diabetes
- ❑ Heart Failure
- ❑ CNS Disorder
- ❑ Current Active Infection
- ❑ Malignancy
- ❑ Immunosuppressive Therapy
- ❑ Pt lives in a region endemic for bacterial, mycobacterial or fungal infection
- ❑ Immunizations up to date
- ❑ Other:____________
- ❑ ____________

TREATMENT ARRANGEMENTS

SHIP MEDS
❑ Home ❑ Doctors Office

Infusion by: ❑ Special Design Healthcare ❑ Drs. Office ❑ Other ____________
Teaching by: ❑ Special Design Healthcare ❑ Drs. Office ❑ Other ____________

Is this the first dose? ❑ Yes ❑ No If no, date first dose given: ________ ❑ start ASAP Next dose due: ____________

ETANERCEPT (Enbrel® Sure Click)
28 Day Supply
- ❑ Maintenance dose of 50 mg SQ weekly
- ❑ Children (2-17 yo) 0.8 mg/kg/wk (up to 50 mg/wk) once weekly as a ❑ single injection or ❑ two injections
- ❑ Other Regimen:____________
- ❑ Refills x_____

ADALIMUMAB (Humira® PEN)
28 Day Supply
- ❑ MAINTENANCE HUMIRA* Self-Injectable Pen 40mg/0.8ml (once every 14 days)
- ❑ Other regimen____________

Refills x____

CERTOLZIFUMAB PEGOL (Cimzia®)
28 Day Supply
- ❑ 400 mg SQ. on Weeks 0, 2, 4 and then every 4 weeks

Refills x____

ABATACEPT (Orencia®)
28 Day Supply
- ❑ Infuse_______mg IV in 100ml NS over 30 minutes on week 0, 2, 4 and then every 4 weeks.
- ❑ NS Syringe 10ml IV before and after infusion and as needed. #QS.

Refill x____

Weight	Dose
0 - 60kg	= 250mg
60 - 100kg	= 500mg
>100kg	= 750mg

INFLIXIMAB (Remicade®)
56 Day Supply
- ❑ Infuse 3 mg/kg in 250NS over 2hrs at week 0,2, 6 And then every 8 weeks
  - ❑ Round order up or down to nearest 100mg
  - ❑ Exact dose
- ❑ Other Regimen ____________
- ❑ NS Syringe 10ml IV before and after infusion and as needed. #QS.

Refills x____

BELIMUMAB (Benlysta®)
28 Day Supply
- ❑ Infuse 10mg/kg diluted in 250ml of NS over one hour at week 0, 2, 4 and then every 4 weeks
- ❑ NS Syringe 10ml IV before and after infusion and as needed. #Qs

Refills x_______

Other Orders:

Premedications
***Give 30 minutes before infusion**
- ❑ Diphenhydramine (Benadryl®) 25mg Orally x1
- ❑ Acetaminophen (Tylenol®) 650 mg Orally x1
- ❑ Methylprednisolone (Solu-Medrol®) _______ mg IV x1

Authorized x1 year

Adverse Reactions
- ❑ Acetaminophen (Tylenol®) 650 mg ORALLY for fever or mild discomfort x1.
- ❑ Diphenhydramine (Benadryl®) 50 mg ORALLY for mild to moderate allergic reactions x1
- ❑ EPIPEN (1:1000) 0.3ml IM for anaphylactic reactions, contact physician & call 911.

Authorized x1 year

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

Prescriber Signature: ____________________ ____________________ Date: ____________
May Substitute Dispense as Written