Rheumatology
Infusion Orders

DELIVERIT™ Infusion & Specialty
Phone +1.832.939.8137
Fax: +1.832.939.8128

Patient Demographic Information

Patient Name		**DOB**		**Gender**	Male ☐ Female ☐	**Weight**	____ lbs ☐ kg ☐
SSN		**Phone**		**Allergies**			
Address		**City**		**State**		**Zip Code**	

Medical Information

ICD-10 Diagnosis Code		**Diagnosis**	
Prior Therapies		**Injection Training Required**	☐ Yes ☐ No
Concamitant Medications		**Lab Data**	
Additional Comments		**Does the patient have an active infection?**	☐ Yes ☐ No
Start Date		**Review Date**		**Date since last infusion/injection**	

☐ M 06.9 Rheumatoid arthritis,unspecified
☐ M 08.00 Unspecified juvenile rheumatoid arthritis of unspecidied site
☐ M 08.3 Juvenile rheumatoid polyarthritis (seronegative)
☐ M 45.9 Ankylosing spondylitis of unspecified sites in spine
☐ L 40.49 Other Psoriatic Anthropathy Description:_____
☐ Other Diagnosis : ICD-10 Code_____
Date of the Diagnosis:_____
Has a TB test has been performed? ☐ Yes ☐ No

Patient Insurance Information

Primary Insurance		**Name of the Insured**		**Relationship**	
Member ID#		**Group #**		**Insurance Phone #**	
Secondary Rx Carrier		**Rx ID #**		**Rx Group #**	

Drug Therapy Information

Medication	Directions	Quantity	Refills
☐ **Actemra**	☐ **162mg/0.9mL** Autoinjector ☐ **162mg/0.9mL** Pre-filled Syringe ☐ **80mg/4mL** Vial ☐ **200mg/10mL** Vial ☐ **400mg/20mL** Vial **Pre-medication Orders:** ☐ Solu-Cortef 100mg IVP ☐ Cetirzine 10mg ☐ Diphenhydramine_____mg ☐ Solumedrol 125mg IVP ☐ Acetaminophen _____mg		
☐ **Benlysta**	☐ **120mg** Vial ☐ **400mg** Vial ☐ **200mg/mL** Vial ☐ **400mg/20mL** Vial **Pre-medication Orders:** ☐ Acetaminophen _____mg PO ☐ Diphenhydramine_____mg		
☐ **Cimzia**	☐ **200mg/mL** Vial Kit ☐ **200mg/mL** Starter Kit ☐ **200mg/mL** Prefilled Syringe		
☐ **Cosentyx**	☐ **200mg/mL** Vial Kit ☐ **150mg/mL** (300 mg dose)Prefilled Syringe ☐ **200mg/mL** Starter Kit ☐ **150mg/mL** Prefilled Syringe **Pre-medication Orders:** ☐ Acetaminophen_____mg		

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Drug Therapy Information

Medication	Directions	Quantity	Refills
☐ **Enbrel**	☐ **50mg/mL** SureClick Autoinjector ☐ **50mg/mL** Prefilled Syringe ☐ Enbrel Mini **50mg/mL** Cartridge ☐ **25mg/0.5mL** Prefilled Syringe ☐ **25mg** Vial		
☐ **Humira**	☐ **10mg/0.2mL** Prefilled Syringe ☐ **10mg/0.1mL** Prefilled Syringe (citrate-free) ☐ **20mg/0.4mL** Prefilled Syringe ☐ **20mg/0.2mL** Prefilled Syringe (citrate-free) ☐ **40mg/0.4mL** Prefilled Syringe (citrate-free) ☐ **40mg/0.8mL** Prefilled Syringe ☐ **40mg/0.8mL** Pen ☐ **40mg/0.4mL** Pen (citrate-free)		
☐ **Inflectra**	☐ **100mg** Vial **Pre-medication Orders:** ☐ Acetaminophen _____mg ☐ Lortatdine 10mg ☐ Diphenhydramine _____mg PO ☐ Solu-Cortef_____ mg ☐ Cetirzine 10mgPO ☐ Solu-Medrol 62.5mg IVP ☐ Solu-Medrol 125mg IVP		
☐ **Kevzara**	☐ **150mg/1.14 mL** Prefilled Pen ☐ **200mg/1.14 mL** Prefilled Pen ☐ **150mg/1.14 mL** Prefilled Syringe ☐ **200mg/1.14 mL** Prefilled Syringe		
☐ **Olumiant**	☐ **2mg** Tablet		
☐ **Orencia**	☐ **250mg** Vial ☐ **125mg/mL** Prefilled Syringe ☐ **125mg/mL** ClickJet Autoinjector ☐ **87.5mg/0.7mL** Prefilled Syringe ☐ **50mg/0.4mL** ClickJet Autoinjector		
☐ **Otezla**	☐ **30mg**Tablet ☐ **Starter Pack (28-day)** ☐ **Starter Pack (2 weeks)**		
☐ **Remicade**	☐ **100mg** Vial **Pre-medication Orders:** ☐ Acetaminophen _____mg ☐ Cetirzine **10mgPO** ☐ Lortatdine **10mg** ☐ Solu-Cortef _____ mg ☐ Diphenhydramine_____mg PO ☐ Solu-Medrol **125mg IVP** ☐ Solu-Medrol **62.5mg IVP**		
☐ **Renflexis**	☐ **100mg** Vial **Pre-medication Orders:** ☐ Acetaminophen _____mg ☐ Zyrtec **10mg** ☐ Diphenhydramine_____mg PO ☐ Claritin **25mg**		
☐ **Rituxan**	☐ **100 mg/10 mL** Vial ☐ **500 mg/50 mL** Vial **Pre-medication Orders:** ☐ Acetaminophen _____mg ☐ Methylprednisolone _____mg IV		
☐ **Simponi**	☐ **50mg/0.5mL** Prefilled Syringe ☐ **100mg/mL** Prefilled Syringe ☐ **100mg/mL** SmartJet Autoinjector ☐ **50mg/0.5mL** SmartJet Autoinjector		

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Medication	Directions	Quantity	Refills
☐ **Simponi Aria**	☐ **50mg/4mL** Vial **Pre-medication Orders:** ☐ Diphenhydramine _____ mg IV or PO		
☐ **Stelara**	☐ **45mg/0.5mL** Vial ☐ **45mg/0.5mL** Prefilled Syringe ☐ **90mg/mL** Prefilled Syringe		
☐ **Taltz**	☐ **80mg/mL** Autoinjector ☐ **80mg/mL** Prefilled Syringe		
☐ **Xeljanz**	☐ **5 mg** Tablet		
☐ **Xeljanz XR**	☐ **11 mg** Extended-Release Tablet		

Prescriber Insurance Information

Prescriber Name		**NPI#**		**Office #**		**Fax #**	
Address		**City**		**State**		**Zip Code**	

☐ I Authorize DeliverIt specialty pharmacy to initiate Prior Authorizations on my behalf.

☐ DAW (Dispense as written).

Prescriber certifies that this referral form contains an original signature and is signed by the treating prescriber. No stamped signatures will be accepted. Where required by law, send electronic prescription or on official state prescription blank. In the event requested agent is not available through DeliverIt Group, this prescription shall be forwarded to an eligible pharmacy.

Date

Prescriber's Signature

X _____

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