PHYSICIAN REFERRAL FORM (Rheumatology)

NOTE: DISPENSING OF GENERIC FORMULATION IS AUTHORIZED UNLESS "BRAND MEDICALLY NECESSARY" IS INDICATED

FAMILY PHARMACY VITAL CARE
1720 Hillcrest Drive
Vernon, TX 76384
Phone 940-552-2999 • Fax 940-552-5347

Name: _____ DOB: _____

Pt Wt: _____ Pt Ht: _____ Pt Allergies: _____

*Please attach Demographics page and relevant labs

Diagnosis: _____

Medications:

- ☐ Remicade ___ mg/kg IV at 0, 2 and 6 weeks, then every 8 weeks
- ☐ Inflectra ___mg/kg IV at 0, 2 and 6 weeks, then every 8 weeks
- ☐ Renflexis ___mg/kg IV at 0, 2 and 6 weeks, then every 8 weeks
- ☐ Orencia ___mg IV at 0,2, and 4 weeks, then every 4 weeks
- ☐ Benlysta __mg/kg IV every 2 weeks x3 doses, then every 4 weeks thereafter
- ☐ Stelara subcutaneously initially and 4 weeks later, followed by subcutaneously every 12 weeks – pharmacy to dose based on patient's weight (Psoriatic Arthritis)
- ☐ Simponi Aria 2mg/kg IV at weeks 0 and 4, then every 8 weeks
- ☐ _____

Quantity: ☐1 Year ☐_____

Premedications:

☐ _____

IV Access:

Place and administer medication through:

☐ Peripheral IV ☐ _____

Anaphylaxis Protocol:

☐ Anaphylaxis kit per pharmacy protocol

IV Maintenance Protocol:

☐ Dispense necessary flushes per pharmacy protocol

☐ Maintain IV access per Home Health or pharmacy protocol

Labs:

☐ CBC w/diff ☐ CMP ☐ CRP ☐ ESR ☐ BMP ☐ _____

Prescriber: _____ **NPI:** _____

Prescriber Signature: _____ **Date:** _____