Mercy LTC & Specialty Pharmacy
A Member of Mercy Pharmacy Group

RHEUMATOLOGY

PATIENT PRESCRIPTION REFERRAL FORM:

Refer via phone at: 562-402-0542 or Refer via fax at: 562-402-4629
Today's Date: Need By:
E-prescribing: NCPDP: NPI:

Revised 09/16/2024

Patient Demographics: (Provide the following or attach patient demographic sheet)

Patient Name:
Home Phone: Alt. Phone:
Date of Birth: SS #:
Address:
City, State, Zip:
Gender: Allergies:
Height: Weight:

Prescriber Office: (Please provide as much information as possible)

Prescriber's Name:
NPI:
Phone:
Fax:
Specialty:
Tax ID#:
DEA:
Address:

Insurance Information: (Please copy and attach the front and back of the patient's insurance card)

Primary Insurance: Name of Insurer:
ID#: BIN#: PCN#: Group: Phone:
Secondary Insurance: Name of Insurer:
ID#: BIN#: PCN#: Group: Phone:

Medication Delivery: ☐ Infuse in MIC Patient Address ☐ Always to Physicians Office ☐ First fill to Physician's Office, refills to Patient Address ☐ Pick up at Pharmacy

Diagnostic Information:
Date of Diagnosis **OR** Years with Disease:

Injection Training & Educational Needs:

☐ Specialty Pharmacy Injection Training Requested
☐ Manufacturer's Patient Assistance Program Enrollment Requested
☐ Prescriber's office will train patient OR (choose one)
☐ Prescriber's office already trained patient ☐ Patient is already independently injecting

Requested Clinical Information (if applicable)

Does patient have a latex allergy? ☐ Yes ☐ No
Has Hepatitis B been ruled out? ☐ Yes ☐ No
Does patient have active infection? ☐ Yes ☐ No
Has TB test been performed? ☐ Yes ☐ No
Patient diagnosed with Heart Failure? ☐ Yes ☐ No If Yes, Results:
Additional Comments:

Prior (Failed) Medications (Reason for DC)

DRUG NAME	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
Remicade®	☐ **Remicade** 100 mg Vial DAW:1 (Please initial)	**INITIAL DOSE:** ☐ 3mg/kg DOSE = mg **IV** at week 0, 2, and 6 ☐ 5mg/kg DOSE = mg **IV** at week 0, 2, and 6 ☐ 10mg/kg DOSE = mg **IV** at week 0, 2, and 6 ☐ Other	**INITIAL DOSE (no refills):** vials/ infusion	
		MAINTENANCE DOSE: mg **IV** every 8 week Other	**MAINTENANCE DOSE:** vials/ infusion	
Infliximab®	☐ **Infliximab** 100 mg Vial	**INITIAL DOSE:** ☐ 3mg/kg DOSE = mg **IV** at week 0, 2, and 6 ☐ 5mg/kg DOSE = mg **IV** at week 0, 2, and 6 ☐ 10mg/kg DOSE = mg **IV** at week 0, 2, and 6 ☐ Other	**INITIAL DOSE (no refills):** vials/ infusion	

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		MAINTENANCE DOSE: mg **IV** every 8 weeks Other	**MAINTENANCE DOSE:** vials/ infusion	
Renflexis®	☐ **Renflexis** 100 mg Vial	**INITIAL DOSE:** ☐ 3mg/kg DOSE = mg **IV** at week 0, 2, and 6 ☐ 5mg/kg DOSE = mg **IV** at week 0, 2, and 6 ☐ 10mg/kg DOSE = mg **IV** at week 0, 2, and 6 ☐ Other	**INITIAL DOSE (no refills):** vials/ infusion	
		MAINTENANCE DOSE: mg **IV** every 8 weeksL Other	**MAINTENANCE DOSE:** vials/ infusion	
Skyrizi®	☐ **Skyrizi** 150 mg/mL prefilled pen ☐ **Skyrizi** 150 mg/mL prefilled syringe ☐ **Skyrizi** 75 mg/0.83 mL prefilled syringe	**INITIAL DOSE** Inject 150 mg **SQ** at week 0,4 Other	**INITIAL DOSE (no refills):** ☐ 2 boxes ☐ Other	
		MAINTENANCE DOSE: Inject 150 mg **SQ** every 12 weeks Other	**MAINTENANCE DOSE:** ☐ 1 box ☐ Other	
IVIG®	**Specify Brand**	**INITIAL DOSE:** Infuse 2 g/kg **IV** over 2-5 days Other infuse g/kg **IV** over day/s	**INITIAL DOSE (no refills):** total of grams	
	Specify Brand	**MAINTENANCE DOSE:** Infuse 1 g/kg **IV** over day/s every week/s Other infuse g/kg **IV** over day/s every week/s	**MAINTENANCE DOSE:** total of grams	
SCIG®	**Specify Brand**	Infuse g/kg **SQ** every week/s	total of grams	
Stelara®	☐ **Stelara** 45 mg/0.5 mL prefilled syringe ☐ **Stelara** 90 mg/mL prefilled syringe	**INITIAL DOSE:** ☐ inject 45 mg **SQ** at week 0,4 ☐ inject 90 mg **SQ** at week 0,4 ☐ Other	**INITIAL DOSE (no refills):** ☐ 2 boxes ☐ Other	
		MAINTENANCE DOSE: ☐ inject 45 mg **SQ** every 12 weeks ☐ inject 90 mg **SQ** every 12 weeks ☐ Other	**MAINTENANCE DOSE:** ☐ 1 box ☐ Other	
Humira®	Please specify how many mg/dose Pen or Prefilled Syringe Citrate free or not Other	☐ Inject 40 mg **SQ** every OTHER week ☐ Inject 20 mg **SQ** every OTHER week ☐ Inject 10 mg **SQ** every OTHER week ☐ Other	☐ 4 week supply ☐ Other	

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Tremfya®	☐ **Tremfya 100 mg/ml prefilled syringe** ☐ **Tremfya 100 mg/ml Pen**	**INITIAL DOSE:** ☑ Inject 100 mg **SubQ** at week 0,4 ☐ Other	**INITIAL DOSE (no refills):** ☐ 2 boxes ☐ Other	
		Maintenance dose: ☐ Inject 100 mg **SubQ** every 8 weeks thereafter ☐ Other	**MAINTENANCE DOSE:** ☐ 1 box ☐ Other	
Other				
Physician Signature:		•DAW (Dispense as Written):	**Date:**	

Patient Support Programs: I authorize **Mercy Pharmacy Group** to enroll me in a company-assisted patient support program, corresponding with my prescribed therapy for purposes of receiving additional services such as, but not limited to injection training. I further authorize the release to communicate to the corresponding manufacturer the minimum necessary information about my health condition and prescription(s) to: coordinate the delivery of products and services available through the patient assistance program, aggregate de-identified data for market analysis and provide educational information regarding therapies. I understand that I may refuse t o sign this authorization and that my refusal will

not affect my ability to obtain treatment from the pharmacy. However, I will not be enrolled in the service program listed above, A copy of this authorization will be utilized with the same effectiveness as an original. Ancillary supplies provided as needed for administration

***Patient Signature:** (required for participation) **Date:** •Please select if you would like the patient enrolled in a Manufacturer's Assistance Program **CONFIDENTIALITY NOTICE:** If you are not the intended recipient or the person responsible for delivering it to the intended recipient, you are hereby notified that you are not authorized to read, print, retain, copy or disseminate this message, any part of it, or any attachments. This facsimile message may contain information that is confidential, privileged, proprietary, or otherwise legally exempt from disclosure or use. **Any disclosure or use of this facsimile message by any person other than the intended recipient or person responsible for delivering it to the intended recipient may constitute aFederal criminal offense punishable by imprisonment up to 10 years or fines up to $250,000.** If you have received this message in error, please destroy this message and any accompanying attachments in their entirety without reading the content and notify the sender immediately by telephone of the inadvertent transmission, by calling collect if located outside the calling area. There is no intent on the part of the sender to waive any right or privilege that may be attached to *

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