benevere PHARMACY

60 Market Center Dr. #103, Collierville, TN 38017
O: 901.316.5752 TP: 855.344.8724 F: 901.316.5760 TF: 844.588.5560
beneverepharmacy.com

TODAY'S DATE: _____

☐ NEW PATIENT ☐ CURRENT PATIENT

RHEUMATOLOGY INFUSION ORDER FORM

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 _____

Insurance Phone _____

Secondary Insurance (if applicable) _____

Insurance Phone _____

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 ☐ Plaque-

☐ Previous biologic _____ ☐ Other: _____

Additional medical justification _____

Currently on biologic? ☐ Yes ☐ No How long?: _____ Date of last dose: _____/___/____ This RX is: ☐ New Therapy ☐ Continuing previous treatment

☐ Patient has received injection training ☐ Physician's office to provide injection training ☐ Benevere Rx to coordinate injection training

DRUG NAME	PRESCRIPTION ORDERS *(PLEASE CHECK ONE OR MORE)*	QUANTITY	REFILLS
☐ Actemra (tocilizumab)	Infuse _____ mg once every 4 weeks Dispense: ☐ 80mg vials ☐ 200mg vials ☐ 400mg vials	30 Day Supply	Refills
☐ Orencia (abatacept)	Induction dose: _____ mg every weeks 0, 2, and 4 Maintenance dose: _____ every 4 weeks thereafter	30 Day Supply	Refills
☐ Remicade (infliximab)	Induction dose: _____ mg every weeks 0, 2, and 4 Maintenance dose: _____ every 4 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
☐ Benlysta (belimumab)	Induction dose: _____ mg every weeks 0, 2, and 4 Maintenance dose: _____ every 4 weeks thereafter	30 Day Supply	Refills
Other medications	Directions:	QTY	REFILL

Deliver to: ☐ Patient's home ☐ MD's Office ☐ 1st dose to MD's Office, remaining refills to patient's home

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing below, I hereby authorize CVS Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.

Prescriber's Signature (signature required. NO STAMPS) _____ Date _____