

RHEUMATOLOGY INFUSION ORDER FORM

PATIENT INFORMATION

PRESCRIBER INFORMATION

Patient Name _____
 Address _____
 City _____ State _____ Zip _____
 Home Phone _____ Cell _____
 DOB _____ SSN _____
 Drug Allergies _____ Male Female

Prescriber Name _____ Lic# _____
 DEA# _____ Tax ID _____
 Practice Name _____
 Address _____ Suite _____
 City _____ State _____ Zip _____
 Office Phone _____ Fax _____

INSURANCE, MEDICARE OR MEDICAID INFORMATION

Primary Insurance _____ Secondary Insurance (if applicable) _____
 Policy # _____ Group _____ Policy # _____ Group _____
 Insurance Phone _____ Insurance Phone _____
 Prescription Drug Coverage: Company _____ Phone _____
 RXGRP# _____ RXBIN# _____ PCN/ID# (if available) _____

COMPLETE OR FAX FRONT AND BACK COPIES OF INSURANCE, PRESCRIPTION AND/OR CO-PAY ASSISTANCE CARDS

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
<input type="checkbox"/> Actemra (tocilizumab)	Infuse _____ mg once every 4 weeks Dispense: <input type="checkbox"/> 80mg vials <input type="checkbox"/> 200mg vials <input type="checkbox"/> 400mg vials	30 Day Supply	Refills
<input type="checkbox"/> Orencia (abatacept)	Induction dose: _____ mg every weeks 0, 2, and 4 Maintenance dose: _____ every 4 weeks thereafter	30 Day Supply	Refills
<input type="checkbox"/> Remicade (infliximab)	Induction dose: _____ mg every weeks 0, 2, and 4 Maintenance dose: _____ every 4 weeks thereafter	30 Day Supply	Refills
<input type="checkbox"/> Rituxan (rituximab)	Infuse _____ mg on Day 1 and Day 15 Dispense: <input type="checkbox"/> 100mg vials <input type="checkbox"/> 500mg vials	30 Day Supply	Refills
<input type="checkbox"/> 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

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

Prescriber's Signature (signature required. NO STAMPS)

Date

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