Zarina Pharmacy
SPECIALTY & INFUSION

Pediatric Rheumatology A-M

Fax: 832-886-4298 Phone: 832-886-4296 zarinapharmacy.com

Need By Date: _____ Ship To: ☐ Patient ☐ Office ☐ Other _____ Fax Copy: ☐ Rx Card Front/Back ☐ Clinical Notes ☐ Medical Card Front/Back

Patient Information

Patient Name	
Address	
City State ZIP	
Main Phone	Alternate Phone
Social Security #	
Date of Birth	☐ Female ☐ Male

Prescriber Information

Prescriber Name		
Address		
City State ZIP		
Phone	Fax	
Contact Person		
DEA #	NPI #	License #

Clinical Information

Diagnosis: ☐ M08.0 Juvenile Idiopathic Arthritis ☐ H20.9 Uveitis ☐ L40.50 Psoriatic Arthritis
☐ Other: _____ Dx Code: _____

Location: Joints: ☐ Hands ☐ Feet ☐ Knees ☐ Spine
☐ Other: _____

Prior Failed Meds: _____ Length of Treatment: _____ Reason for Discontinuing: _____
_____ Length of Treatment: _____ Reason for Discontinuing: _____
_____ Length of Treatment: _____ Reason for Discontinuing: _____

Drug Allergies		Latex Allergy: ☐ No ☐ Yes
Weight ☐ kg ☐ lbs	TB Test: ☐ No ☐ Yes Date: _____ Results: ☐ Negative ☐ Positive (please send lab results)	Status: ☐ New ☐ Restart ☐ Continuing

Prescription Information

			Qty	Refills
☐ Actemra®	162 mg ☐ Autoinjector ☐ PFS Vials: ☐ 80 mg/4 mL ☐ 200 mg/10 mL ☐ 400 mg/20 mL	**Polyarticular Juvenile Idiopathic Arthritis** Subcutaneous: ☐ Inject 162 mg SUBQ every 3 weeks (<30 kg) ☐ Inject 162 mg SUBQ every 2 weeks (≥30 kg) Intravenous: ☐ Infuse _____ mg (10 mg/kg) every 4 weeks (<30 kg) ☐ Infuse _____ mg (8 mg/kg) every 4 weeks (≥30 kg) **Systemic Juvenile Idiopathic Arthritis** Subcutaneous: ☐ Inject 162 mg SUBQ every 2 weeks (30 kg) ☐ Inject 162 mg SUBQ every week (≥30 kg) Intravenous: ☐ Infuse _____ mg (12 mg/kg) every 2 weeks (<30 kg) ☐ Infuse _____ mg (8 mg/kg) every 2 weeks (≥30 kg)	4 Week Supply	_____
☐ Benlysta®	200 mg ☐ Autoinjector ☐ PFS Vials: ☐ 120 mg ☐ 400 mg	☐ Inject 200 mg SUBQ once a week ☐ Load: Infuse _____ mg (10 mg/kg) at weeks 0, 2, and 4, then every 4 weeks thereafter ☐ Maintenance: Infuse _____ mg (10 mg/kg) every 4 weeks	4 Week Supply Loading Dose 4 Week Supply	_____ None _____
☐ Cosentyx®	☐ 75mg PFS 150mg ☐ Pen ☐ PFS	☐ Load: Inject 75 mg SUBQ on week 0, 1, 2, 3 (≥15 kg to <50 kg) ☐ Maintenance: Inject 75 mg SUBQ on week 4, then every 4 weeks therafter (≥15 kg to <50 kg) ☐ Load: Inject 150 mg SUBQ on week 0, 1, 2, 3 (≥50 kg) ☐ Maintenance: Inject 150 mg SUBQ on week 4, then every 4 weeks thereafter (≥50 kg)	4 Week Supply 4 Week Supply 4 Week Supply 4 Week Supply	None _____ None _____
☐ Enbrel®	50 mg ☐ SureClick® ☐ PFS ☐ Mini ☐ 25 mg PFS ☐ 25 mg/0.5 mL SDV	☐ Inject 50 mg SUBQ once a week (≥63 kg) ☐ Inject 25 mg SUBQ once a week ☐ Inject _____ mg (0.8 mg/kg) SUBQ once a week (<63 kg)	4 Week Supply 4 Week Supply 4 Week Supply	_____ _____ _____
☐ Humira® Citrate Free	☐ 10 mg PFS ☐ 20 mg PFS 40 mg ☐ PFS ☐ Pen	☐ Inject 10 mg SUBQ every other week (10 kg to <15 kg) ☐ Inject 20 mg SUBQ every other week (15 kg to <30 kg) ☐ Inject 40 mg SUBQ every other week (≥30 kg)	4 Week Supply	_____
☐ Other				

By signing this form, you are authorizing BioPlus Specialty Pharmacy and its employees to serve as your designated agent in submitting clinical and other required information to third party payers with respect to this prescription and any refills or continuation of the same medication and dose for this patient. IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged property, or exempt from disclosure under applicable law. If you are not the named addressee you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.

Prescriber's Signature (no stamps) **Substitution Permitted** _____ **Date** _____

Prescriber's Signature (no stamps) **Dispense As Written** _____ **Date** _____

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Drug Allergies		Latex Allergy: ☐ No ☐ Yes
Weight ☐ kg ☐ lbs	TB Test: ☐ No ☐ Yes Date: _____ Results: ☐ Negative ☐ Positive (please send lab results)	Status: ☐ New ☐ Restart ☐ Continuing

Prescription Information

			Qty	Refills
☐ Orencia®	☐ 50 mg PFS ☐ 87.5 mg PFS ☐ 125 mg PFS ☐ 250 mg Vial	☐ Inject 50 mg SUBQ weekly (10 kg to <25 kg) ☐ Inject 87.5 mg SUBQ weekly (25 kg to <50 kg) ☐ Inject 125 mg SUBQ weekly (≥50 kg) ☐ Load: Infuse 1000 mg IV at weeks 0, 2, 4, then every 4 weeks thereafter (>100 kg) ☐ Load: Infuse 750 mg IV at weeks 0, 2, 4, then every 4 weeks thereafter (75 kg to 100 kg) ☐ Load: Infuse _____ mg (10 mg/kg) IV at weeks 0, 2, 4, then every 4 weeks thereafter (<75 kg) ☐ Maintenance: Infuse _____ mg IV every 4 weeks	4 Week Supply Loading Dose 4 Week Supply	_____ None _____
☐ Rinvoq®	☐ 1 mg/mL Oral Solution ☐ 15 mg ER Tablet	☐ Take 3 mL by mouth twice daily (10 kg to <20 kg) ☐ Take 4 mL by mouth twice daily (20 kg to <30 kg) ☐ Take 6 mL by mouth twice daily (≥30 kg) ☐ Take 1 tablet by mouth once daily (≥30 kg)	4 Week Supply 4 Week Supply 4 Week Supply 30 Tablets	_____ _____ _____ _____
☐ Stelara® Psoriatic Arthritis	☐ 45 mg Vial (<60 kg)	☐ Starter: Inject _____ mg (0.75 mg/kg) SUBQ on week 0 ☐ Maintenance: Inject _____ mg (0.75 mg/kg) SUBQ on week 4, then every 12 weeks thereafter	1 Vial 1 Vial	None _____
	☐ 45 mg PFS (≥60 kg) ☐ 90 mg PFS (>100 kg with Ps)	☐ Starter: Inject 1 syringe SUBQ on week 0 ☐ Maintenance: Inject 1 syringe SUBQ on week 4, and then every 12 weeks thereafter	1 Syringe 1 Syringe	None _____
☐ Xeljanz®	☐ 1 mg/mL Oral Solution ☐ 5 mg Tablet	☐ Take 3.2 mL by mouth twice daily (10 kg to <20 kg) ☐ Take 4 mL by mouth twice daily (20 kg to <40 kg) ☐ Take 5 mL by mouth twice daily (≥40 kg) ☐ Take 5 mg by mouth twice daily (≥40 kg)	4 Week Supply 4 Week Supply 4 Week Supply 60 Tablets	_____ _____ _____ _____
☐ Other				

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