Mercy LTC & Specialty Pharmacy
A Member of Mercy Pharmacy Group

FAX: 562.402.4629

DERMATOLOGY

Version: 3/14/2025

PATIENT INFORMATION

Patient Name: DOB: Patient Phone:

Allergies: Weight lbs/kg: Height:

DIAGNOSIS

Diagnosis/ICD 10:

Documentation

- ☐ Demographic info, H&P, insurance info, labs results, 2-3 clinical visit notes (as appropriate)
- ☐ Premedications per pharmacy protocol
- ☐ Premeds: _____

IV line: ☐ Peripheral ☐ PICC ☐ PORT ☐ Other

Flushing Protocol: IV Line Flushing direction will be followed as per Mercy LTC & Specialty Pharmacy flushing protocol based on SASH/SAS technique With Normal Saline flushes and/or Heparin (10U/mL Or 100U/mL) based on IV line.

Skilled Nursing Care: Providing medication(s) via venous access or subcutaneous access in accordance with medication orders. Evaluation and documentation of health status, therapy response, and educational needs. Provide support and assistance as required.

MEDICATION	DOSE/STRENGTH	DIRECTIONS FOR USE	QTY	REFILLS
☐ **REMICADE** ☐ **RENFLEXIS** ☐ **INFLIXIMAB**	☐ 100 mg vial (Round the dose as per closest vial sizes)	**Initial Dose:** ☐ 3 mg/kg = mg IV at week 0, 2, and 6 ☐ 5 mg/kg = mg IV at week 0, 2, and 6 ☐ 10 mg/kg = mg IV at week 0, 2, and 6	**Initial** #:	
		Maintenance Dose: ☐ _____ mg IV every 8 weeks	**Maintenance** #	
SKYRIZI®	☐ 150 mg/mL prefilled pen ☐ 150 mg/mL prefilled syringe ☐ 75 mg/0.83mL prefilled syringe	**Initial Dose:** ☐ Inject _____ mg at week 0, 4, and 8	**Initial** _____ vials	
		Maintenance Dose: ☐ _____ mg SQ on week 12 then every 8 weeks	**Maintenance** #	
IVIG®	Specify Brand:	**Initial Dose:** ☐ Infuse 2 g/kg IV over 2-5 days	**Initial** _____ grams	
		Maintenance Dose: ☐ Infuse 1 g/kg IV over _____ days every _____ weeks	**Maintenance** _____ grams	
SCIG®	Specify Brand:	☐ Infuse _____ g/kg IV over _____ days every _____ weeks	_____ grams	
STELARA®	☐ 45 mg/0.5 mL PF Syringe ☐ 90 mg/mL PF Syringe	**Initial Dose:** ☐ Inject 45 mg SQ at week 0, 4 ☐ Inject 90 mg SQ at week 0, 4	**Initial:**	
		Maintenance Dose: ☐ Inject 45 mg SQ every 12 weeks	**Maintenance** 1 box	

		◯ Inject 90 mg SQ every 12 weeks		
HUMIRA®	◯ Humira Starter Kit ◯ Adult Crohn's, UC start kit ◯ Pediatric Crohn's start kit	**Initial Dose:** ◯ Inject 10 mg SQ every OTHER week ◯ Inject 20 mg SQ every OTHER week ◯ Inject 40 mg SQ every OTHER week	**Initial** ◯ 1 kit	
	◯ Pen ◯ Prefilled Syringe ◯ Citrate free	**Maintenance Dose:** ◯ _____ mg SQ every _____ week start on day 29	**Maintenance** _____ weeks	
TREMFYA	◯ 100 mg/mL PF syringe ◯ 100 mg/mL Pen	**Initial Dose:** ◯ Inject 100 mg SQ at week 0,4	**Initial** ◯ 2 boxes	
		Maintenance Dose: ◯ Inject 100 mg SQ every 8 weeks thereafter	**Maintenance** ◯ 1 box	
Actemra	◯ IV ◯ SQ prefilled syringe ◯ SQ Prefilled autoinjector	◯ _____ mg IV every _____ week ◯ _____ mg SQ every _____ week	Qty #	
OTHER				

PROVIDER INFORMATION

Disclaimer: Mercy LTC & Specialty Pharmacy and its representatives are authorized to provide medical necessity attestations, secure coverage, initiate the prior authorization process, and collect and submit lab results and other patient data as part of the authorization process as my authorized agent. This authorization is valid until revoked in writing by me. Mercy LTC & Specialty Pharmacy may also forward this information and any related materials related to the coverage of this product to the insurer's provider network if it cannot fulfill this prescription.

Provider/Practice Name: Contact Person:

Provider NPI: Phone: Fax:

Provider Signature **DAW (Dispense as Written)** **Date**

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