Mercy LTC & Specialty Pharmacy
A Member of Mercy Pharmacy Group

FAX: 562.402.4629

RHEUMATOLOGY

Version: 3/13/2025

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** Qty #	
		Maintenance Dose: ☐ _____ mg IV every 8 weeks	**Maintenance** Qty #	
SKYRIZI®	☐ 150 mg/mL PF pen ☐ 150 mg/mL PF Syringe ☐ 75 mg/0.83mL PF Syringe	**Initial Dose:** ☐ Inject _____ mg at week 0, 4, and 8	**Initial** Qty #	
		Maintenance Dose: ☐ _____ mg SQ on week 12 then every 8 weeks	**Maintenance** Qty #	
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:** Qty #	
		Maintenance Dose: ☐ Inject 45 mg SQ every 12 weeks ☐ Inject 90 mg SQ every 12 weeks	**Maintenance** Qty #	
HUMIRA®	☐ Pen ☐ PF Syringe	**Initial Dose:** ☐ _____ mg Sq every _____ week for _____ weeks	**Initial** Qty #	
	☐ Pen ☐ PF Syringe	**Maintenance Dose:** ☐ _____ mg SQ every _____ week start on day 29	**Maintenance** Qty #	

Enbrel	◯ 25 mg/0.5 mL PF Syringe ◯ 50 mg/mL PF Syringe ◯ 50 mg/mL Autoinjector ◯ 25 mg/0.5 mL vial ◯ 50 mg/mL Mini® prefilled cartridge for use with the AutoTouch® reusable autoinjector only	**Initial Dose:** ◯ _____ mg, number of doses _____ per week for _____ months	**Qty #**	
		Maintenance Dose: ◯ _____ mg once weekly for _____ months	**Qty #**	
TREMFYA	◯ 100 mg/mL PF syringe ◯ 100 mg/mL Pen	**Initial Dose:** ◯ Inject 100 mg SQ at week 0,4	**Initial** Qty #	
		Maintenance Dose: ◯ Inject 100 mg SQ every 8 weeks thereafter	**Maintenance** Qty #	
Krystexxa	IV	◯ 8 mg via IV route every _____ weeks	Qty #	
Actemra	◯ IV ◯ SQ PF syringe ◯ SQ PF autoinjector	◯ _____ mg every _____ week	Qty #	
Rasuvo	SQ PF autoinjector	◯ _____ mg every _____ week for _____ weeks	Qty #	
Cosentyx	◯ IV 125 mg/5 mL ◯ SQ PF Syringe ◯ 300 mg/2mL ◯ 150 mg/1mL ◯ 75 mg/0.5mL	**Initial Dose:** ◯ _____ mg at week _____ for _____ doses	Qty #	
		Maintenance Dose: ◯ _____ mg every _____ weeks for _____ weeks	Qty #	
Cimzia	◯ 200 mg single-dose vial ◯ 200 mg/mL PF syringe	**Initial Dose:** ◯ _____ mg at Week 0, 2 and 4	Qty # 3	
		Maintenance Dose: ◯ _____ mg every 2 weeks	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**

Confidentiality Statement: This referral form is intended solely for the use of the individual or entity to whom it is addressed. It contains confidential information that is protected by law. Unauthorized use, disclosure, or distribution of this form is strictly prohibited. If you have received this form in error or were not the intended recipient, please contact Mercy LTC & Specialty Pharmacy immediately at (562) 402-0542 and return or destroy all copies of the form.