SimfaRose
Pharmaceutical Specialties
Your Symphony Of Healthcare • Transition Care Specialist

10016 Pines Blvd
Pembroke Pines, FL 33024
Phone: 888-797-4632
Fax: 844-246-3364
ePrescribe

765 Morris Park Ave
Bronx, NY 10462
Phone: 718-823-6378
Fax: 718-823-6451
ePrescribe

Rheumatoid Order Form

Today's Date: _____ Date Medication Needed: _____

First Delivery to: □ Home OR □ MD Office
Subsequent Delivery to: □ Home OR □ MD Office

Patient Information

Last Name: _____ First Name: _____ Date of Birth: _____ SS#:_____

Address: _____ City: _____ State:_____ Zip:_____

Home Phone: _____ Cell Phone: _____

Diagnosis/ICD-10 Code:_____ Height / Weight / Allergies: _____

Insurance: _____ Policy #: _____

*** * *Please include copy of insurance card * * ***

Clinical Criteria: (Please fax clinicals)

1.) Has the patient tried and failed? □Methotrexate □Sulfalazine □NSAIDs □Other: _____

2.) Active TB is ruled out? □Yes □No

Drug:	Directions & Quantity:	Drug:	Directions & Quantity:
☐ **Actemra®** ☐ Vials ☐ Pre-Filled Syringe	☐ IV: Infuse _____mg via IV every 4 weeks (Quantity:_____) ☐ SQ: Inject 162mg SQ every other week (Qty: 2) ☐ SQ: Inject 162mg SQ every week (Qty: 4)	☐ **Otrexup®**	☐ Inject 7.5mg every week (Qty: 4) ☐ Inject 10mg every week (Qty: 4) ☐ Inject 15mg every week (Qty: 4) ☐ Inject 20mg every week (Qty: 4) ☐ Inject 25mg every week (Qty: 4)
☐ **Cimzia®** ☐ Pre-filled Syringe ☐ Lypholized Powder	☐ INITIAL: Inject 400mg SQ at Day 1, Day 14, and Day 28 (Qty: 6) ☐ MAINTENANCE: Inject 400mg SQ every 4 weeks (Qty: 2) ☐ MAINTENANCE: Inject 200mg SQ every 4 weeks (Qty: 2)	☐ **Simponi®** ☐ SmartJect(Pen) ☐ Pre-Filled Syringe	☐ Inject 50mg SQ once a month (Qty: 1)
☐ **Enbrel®** ☐ SureClick Pen ☐ Pre-Filled Syringe ☐ Vials	☐ Inject 50mg SQ weekly (Qty: 4) ☐ Inject 50mg SQ twice weekly 72-96 hrs apart (Qty: 8) ☐ Inject 25mg SQ twice weekly 72-96 hrs apart (Qty: 8)	☐ **Stelara®** Pre-filled Syringe	☐ INITIAL: Inject 45mg SQ on Day 0 & Day 28 (Qty: 2) ☐ MAINTENANCE:Inject 45mg SQ every 12 weeks (Qty: 1) ☐ INITIAL: Inject 90mg SQ on Day 0 & Day 28 (Qty: 2) ☐ MAINTENANCE:Inject 90mg SQ every 12 weeks (Qty: 1)
☐ **Humira®** ☐ Pen ☐ Pre-Filled Syringe	☐ MAINTENANCE: Inject 40mg SQ every other week (Qty: 2) ☐ MAINTENANCE: Inject 40mg SQ weekly (Qty: 4)	☐ **Rasuvo®**	☐7.5mg ☐10mg ☐12.5mg ☐15mg ☐17.5mg ☐20mg ☐22.5mg ☐25mg ☐27.5mg ☐30mg Inject SQ every week (Qty: 4)
☐ **Orencia®** ☐ Vials ☐ Pre-Filled Syringe	☐ INITIAL: Infuse _____mg via IV, then inject 125mg SQ within 24hrs (Qty: _____) ☐ MAINTENANCE: Inject 125mg SQ weekly (Qty: 4)	☐ **Methotrexate®** ☐ 2.5mg tablet ☐ 25mg/ml Inj. Solution	☐ Take _____mg orally every week (Qty: 28 day supply) ☐ Inject _____ml SC every 7 days the same each week (Qty:_____)
☐ **Otezla®** ☐ Titration Start Pk ☐ Maintenance ☐ Bridge Dose Pack	☐ Take as directed (Qty: 55) *Only for Titration Pack* ☐ Take 30mg twice daily (Qty: 60) ☐ Take 30mg once daily (Qty: 30) ☐ Take 30mg twice daily (Qty: 60) (12 refills) ☐ Take 30mg once daily (Qty: 28) (6 refills)	☐ **Xeljanz®**	Take 5mg tablets twice daily (Qty: 60)
		☐ **Xeljanz XR®**	Take 11mg tablets once daily (Qty: 30)

REFILLS: _____

MD Signature:_____Date:_____

MD Name (Printed):_____NPI:_____DEA:_____

Phone:_____Fax:_____Contact:_____

Address:_____City:_____ State:_____ Zip:_____

SimfaRose
Pharmaceutical Specialties
Your Symphony Of Healthcare • Transition Care Specialist

10016 Pines Blvd
Pembroke Pines, FL 33024
Phone: 888-797-4632
Fax: 844-246-3364
ePrescribe

765 Morris Park Ave
Bronx, NY 10462
Phone: 718-823-6378
Fax: 718-823-6451
ePrescribe

Urology Order Form

Date Needed by: _____

Patient Information

Last Name: _____ First Name: _____

Date of Birth: _____ Social Security: _____

Address: _____ City: _____ State:_____ Zip:_____

Home Phone: _____ Cell Phone: _____

Diagnosis/ICD-10 Code:_____ Height / Weight / Allergies: _____

Insurance: _____ ID #: _____

*****************Please fax copy of insurance card**************

Prescription:

❑**Trelstar 3.75mg Every Month** ❑**Trelstar 11.25mg Every 3 Months** ❑**Trelstar 22.5mg Every 6 Months** Qty: _____ Refills: _____ Inject Intramuscularly by Physician	❑Eligard 7.5mg Every Month ❑Eligard 22.5mg Every 3 Months ❑Eligard 45mg Every 6 Months Qty: _____ Refills: _____ Inject Subcutaneously by Physician	❑Lupron 7.5mg Every Month ❑Lupron 22.5mg Every 3 Months ❑Lupron 30mg Every 4 Months ❑Lupron 45mg Every 6 Months Qty: _____ Refills: _____ Inject Intramuscularly by Physician
❑Tice BCG 50mg Directions: _____ _____ _____ _____ Qty: _____ Refills: _____	❑ Firmagon (Starter Kit) 240mg ❑ Firmagon (Maintenance) 80mg Directions: _____ _____ _____ Qty: _____ Refills: _____	❑ Zoladex 10.8mg ❑ Zoladex 3.6mg Directions: _____ _____ _____ Qty: _____ Refills: _____
❑Xgeva 120mg/1.7ml Vial Directions: _____ _____ _____ _____ Qty: _____ Refills: _____	❑Botox Directions: _____ _____ _____ _____ Qty: _____ Refills: _____	❑Prolia 60mg/1ml Syringe Directions: _____ _____ _____ _____ Qty: _____ Refills: _____

MD Signature (Required):_____Date:_____

MD Name (Printed):_____NPI:_____DEA:_____

Phone:_____Fax:_____Contact:_____

Address:_____City:_____ State:_____ Zip:_____